MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 93-D

Reg. Dist. No. 30

CERTIFICATE OF DEATH

02547

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 406 Shady Nook Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 Shady Nook Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME: Mary A. Abell

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph A. Abell

6. (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) October 31, 1882

8. AGE: Years	Months	Days	If less than one day
62	4	11	____ hr. ____ min.

9. Birthplace Govans, Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER
12. Name John Maddox
13. Birthplace Ireland

MOTHER
14. Maiden Name Anne Doran
15. Birthplace Vermont

16 (a) Informant Mr. Joseph A. Abell
(b) Address 406 Shady Nook Ave., Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 14, 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Md.

18 (a) Funeral director Mills Funeral
(b) Address 4510 Liberty Heights Ave.

19 (a) 3/13/45 (Date rec'd by registrar) (b) H. C. Andrae Deputy Local Registrar

MEDICAL CERTIFICATION

20. Date of death March 11 1945, at 2.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17 1942, to 3-11 1945, and that I last saw her alive on 3-10 1945.

Immediate cause of death	Duration
Congestive Heart Failure	4 mo
Due to Auricular Fibrillation	1
Due to Hypertension	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wilson K. Galbreath M. D. (M. D. or other)
Address 6209 Frederick Ave. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

02548

Reg. Dist. No. 35

1. PLACE OF DEATH:
County: Baltimore
City or town: Ulstetball - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Ulstetball (Rural) Rt 2
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Enon Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Charles Almony

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): April 16, 1893

8. AGE: Years	Months	Days	If less than one day
51	11	3	hrs. min.

9. Birthplace: Balto. Co., Md. (Town, county, and state)
10. Usual occupation: Worker - Balto. Co. Roads
11. Industry or business

FATHER
12. Name: Benj. F. Almony
13. Birthplace: Balto. Co. Md.

MOTHER
14. Maiden name: Lillie May Almony
15. Birthplace: Balto. Co. Md.

18. Informant: Mrs. James Almony
Address: Ulstetball R.F.D. 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 22 1945 (month) (day) (year)
Cemetery or crematory: Stablers Methodist Cemetery
Location: Parkton, Md.
18. Funeral director: Samuel M. Brooks
Address: Sparks, Md.

19. March 22 1945 Mrs. Howard S. Marbline
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19 1945 at 1245 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 11 1944 to May 19 1945
and that I last saw h[illegible] alive on May 19 1945

Immediate cause of death: Cerebral Hemorrhage — DURATION: 1 wk.
Due to: Coronary Occlusion — 1 yr.
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. Cole Bowers M. D. or other
Address: Reg. Freedom Md. Date signed: 3/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

02549

Reg. Dist. No. 7044

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Facility, Ft. Howard, Maryland

How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No. West Balto. St., Taneytown, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: LUTHER A. ANDERS

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 7-4-89

8. AGE: Years	Months	Days	If less than one day
55	8	1	____ hrs. ____ min.

9. Birthplace: Taneytown, Maryland (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: John Anders

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary Jane Heck

15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Facility

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 9 1945 (month) (day) (year)

Cemetery or crematory: Lutheran

Location: Taneytown, Md

18. Funeral director: C. O. Dutrow Son

Address: Taneytown, Md

19. March 9 1945 (Date rec'd by registrar) Ethel M Mehring Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6, 1945, at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 1, 1945, to March 6, 1945

and that I last saw him alive on March 6, 1945

Immediate cause of death	DURATION
Heart Disease, Coronary Arterio-	4 Yrs.
sclerosis, cardiac enlargement	plus
Due to Myocardial insufficiency	
Due to	
Due to	
Other conditions: Broncho-Pneumonia	1 day

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. J. Kenney M. D. or other

Address: Ft. Howard, Maryland Date signed: 3-8-45

C. J. KENNEY, M.D. CLINICAL DIRECTOR

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02550

Reg. Dist. No. 41

1. PLACE OF DEATH:
County BALTIMORE
City or town DUNDALK
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) LIFE

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County BALTO.
City or town DUNDALK Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. P.O.BOX # 7456 GERMAN HILL ROAD
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR NO

3. (a) FULL NAME HELEN ESTELL ARMSTRONG

3. (b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife JOHN D.ARMSTRONG
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB.1 1920

8. AGE: Years	Months	Days	If less than one day
25	1	18	hrs. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual occupation HOUSE WIFE
11. Industry or business AT HOME
FATHER 12. Name CHARLES NORBERG
13. Birthplace BALTO.MD.
MOTHER 14. Maiden name UNKNOWN
15. Birthplace BALTO.MD.
16. Informant JOHN D.ARMSTRONG (HUSBAND)
Address PO.BOX #7456 GERMAN HILL ROAD
17. BURIAL Date thereof MAR.22/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory SACRED HEART CEM.
Location GERMAN HILL ROAD
18. Funeral director Lilly & Bailey Bros.
Address 403 S. WOLFE ST.
19. 3/20 1945 Milton M. Mumaw Local Registrar Deputy
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR.18 1945, at 11 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 1945, to March 18 1945
and that I last saw her alive on March 18 1945

Immediate cause of death	DURATION
Fulminating Tuberculosis (Pulmonary)	
Due to	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. A. Jacobs M.D.
M. D. or other
Address 617 North Pt Road Date signed 3/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A 15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02551

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Rural near Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since Jan. 10, 1942
Hospital, institution, or street address where death occurred:
at home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Rural near Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. Grounds of Sheppard-Pratt Hospital
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Hattie Miranda Mayes Ashe

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Harry Albert Ashe
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): July 25, 1890

8. AGE: Years	Months	Days	If less than one day
54	7	4	...hrs. ...min.

9. Birthplace: Baltimore County, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Nicholas Mayes
13. Birthplace: Baltimore Co.

MOTHER
14. Maiden name: Margaret Ann Wilhelm
15. Birthplace: Baltimore Co.

16. Informant: Harry Albert Ashe
Address: c/o Sheppard-Pratt Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 3/45 (month) (day) (year)
Cemetery or crematory: Salem
Location: Balto Co.
18. Funeral director: Edw C Tipton
Address: Hampstead Md.

19. Mch 1st 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1 1945, at 10:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 16 1944, to Feb. 28 1945
and that I last saw her alive on Feb. 28 1945

Immediate cause of death	DURATION
Inanition	10 day
Due to: Carcinoma of the head of the pancreas with multiple metastases	1½ years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of head of pancreas
Date of op. Nov. 1944
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Francis J. McLaughlin M.D. M. D. or other
Address: 4203 Marblehall Rd. Baltimore Date signed: March 1, 1945

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (5th)

02552

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:
County: Baltimore
City or town: Relay
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, Institution, or street address where death occurred:
1730 Arlington Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Relay
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1730 Arlington Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3. (a) FULL NAME: Clifford Colfax Bonnet

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Hannah Elizabeth Kinghorn Bonnet
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 19 - 1868

8. AGE: Years: 76 | Months: 9 | Days: 26 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Harford Co. Md
(Town, county, and state)

10. Usual occupation: B. & O. clerk
11. Industry or business: Retired

FATHER
12. Name: Richard Amos Bonnet
13. Birthplace: Harford Co. Md

MOTHER
14. Maiden name: ? Nobles
15. Birthplace: Harford Co. Md

16. Informant: Mrs Wm Colfax Bonnet
Address: 1730 Arlington Ave Relay Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 20 42 (month) (day) (year)
Cemetery or crematory: Bayview Cem. Harford Co. Md.
Location: near Havre de Grace

18. Funeral director: John O. Mitchell Sons
Address: 1900 Eutaw Place

19. 3/19 1945 (Date rec'd by registrar) G. W. Hetrick per MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17 19 45 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 43, to March 17 19 45
and that I last saw him alive on March 16 19 45

Immediate cause of death	DURATION
Carcinoma of Rectum & Pelvis	2 yrs
Due to Carcinomatosis	2 yrs
Rt Hemiplegia	1 wk
Due to Arteriosclerosis	
Other conditions Senile City	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: 609 Main St Elkton Md Date signed: 3/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd. U.S.
3/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-E)

CERTIFICATE OF DEATH

02553 P

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Facility, Fort Howard, Maryland

How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ~~Baltimore~~

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 805 Burgundy St.
(If rural, give LOCATION) ✓

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: JOSEPH BAYORAS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 12-17-1895

8. AGE:	Years	Months	Days	If less than one day
	49	2	27	..... hrs. ..... min.

9. Birthplace: Lithuania, Russia
(Town, county, and state)

10. Usual occupation: Tailor

11. Industry or business:

FATHER
12. Name: Pete Bayoras
13. Birthplace: Lithuania

MOTHER
14. Maiden name: Teakli Gurhle
15. Birthplace: Lithuania

18. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 21 1945 (month) (day) (year)

Cemetery or crematory: New National

Location: Frederick Rd.

18. Funeral director: Joseph Kasunskas Inc

Address: 628 Washington Blvd.

19. 3/19 1945 (Date rec'd by registrar) A. W. Hedrick per M.J. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16, 1945, at 2:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13, 1945 to March 16, 1945 and that I last saw him alive on March 16, 1945

	DURATION
Immediate cause of death: Asphyxiation	1 day
Due to: Carcinoma of the trachea	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? No

23. SIGNATURE: C. KENNEY, M.D. CLINICAL DIRECTOR M. D. or other

Address: Fort Howard, Maryland Date signed: 3-16-45

(M) — MARGIN RESERVED FOR BINDING — (1) — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly. — (1) — VS A15

Rec'd U.S.
3/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18-a

CERTIFICATE OF DEATH

02554

Reg. Diat. No. 30

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 12 Beach Drive

(If rural, give LOCATION)

2.(a) If veteran, name war --

3. (a) FULL NAME Harry Henderson Beatty

3. (b) Social Security Number --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	married

6.(b) Name of husband or wife Emma Well 6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) August 10, 1866

8. AGE: Years	Months	Days	If less than one day
78	6	21	..... hrs. ..... min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual occupation farmer

11. Industry or business own farm

FATHER 12. Name Harry Henderson Beatty

13. Birthplace ~~unk~~. Pa.

MOTHER 14. Maiden name Sarah ~~Jones~~ McLANE

15. Birthplace ~~unk~~. Ireland

16. Informant Hospital records

Address Catonsville, Baltimore - 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-7-45 (month) (day) (year)

Cemetery or crematory Uniondale Cemetery

Location Pittsburgh Pa.

18. Funeral director A-Lee Oden

Address 4644 York Rd.

19. 3/4 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1945 at 9:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 23, 1945, to March 3, 1945 and that I last saw him alive on March 3, 1945

	DURATION
Immediate cause of death: Chronic myocarditis	Indef.
Due to: Generalized arteriosclerosis	Indef.
Due to: Chronic interstitial nephritis	Indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert E. Gardner M.D.

Robert E. Gardner, M.D. M. D. or other

Address Baltimore - 28, Md. Date signed 3/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

CERTIFICATE OF DEATH

02555

Reg. Dist. No. 30

1. PLACE OF DEATH:

County

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
108 Forest Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 108 Forest Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Emma Letitia Beaumont

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Pascal Kemp Beaumont

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 25, 1860

8. AGE: Years	Months	Days	If less than one day
84	4	6	..... hrs. ..... min.

9. Birthplace: Baltimore Co., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Elias Thomas
13. Birthplace: Balto. Co., Md.

MOTHER
14. Maiden name: Catherine L. McKnew
15. Birthplace: Prince George Co., Md.

16. Informant: Mrs. Seth Zimmerman
Address: 108 Forest Drive, Catonsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/5/45 (month) (day) (year)

Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 3/3/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-1 19 45, at 12:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-24 19 44 to 3-1 19 45
and that I last saw h[illegible] alive on 2-26 19 45

Immediate cause of death	DURATION
Coronary Embolism	1/2 hr.
Due to: Myocarditis	3 yrs?
Due to: Hypertension	10 yrs?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Roger J. Bean M. D. or other

Address: 803 3rd Ave Date signed: 3-1-45

Deputy Local. Catonsville 28 Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02556

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Pinehurst
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, institution, or street address where death occurred: at home
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Pinehurst
(If outside city or town limits, write RURAL and give nearest town)
Street No. 208 Midhurst Road
(If rural, give LOCATION)
2.(a) If veteran, name war: — none —

3.(a) FULL NAME: Webster Bell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Swormstedt Bell
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): December-16-1874

8. AGE: Years	Months	Days	If less than one day
70	3	0	...hrs. ...min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: Real Estate
11. Industry or business: Self

FATHER
12. Name: William William Bell
13. Birthplace: Balto. Md.

MOTHER
14. Maiden name: Caroline Brandell
15. Birthplace: Long Green, Md.

16. Informant: Mrs Webster Bell (wife)
Address: 208 Midhurst Road.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March-19-45 (month) (day) (year)
Cemetery or crematory: New Cedar Lord
Location: Newley Lord Penna.

18. Funeral director: Stewart Mourn Co.
Address: 108 W North Ave.

19. 3/17 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16 1945, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 1936 to March 16 1945 and that I last saw h. living alive on March 15 1945

Immediate cause of death	DURATION
Arterio Sclerotic heart disease	4 yrs
Due to: age —	
Due to:	
Other conditions: Auricular fibrillation	2 wks

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

SIGNATURE: John A Luetscher M. D. or other
Address: 12 Graper St. Date signed: March 16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02557

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville 28 Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs 10 mo 16 da
Hospital, Institution, or street address where death occurred: Spring Grove State Hospt
How long in hospital or institution? 6 yrs 10 mo 16 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Balto
(If outside city or town limits, write RURAL and give nearest town)
Street No. 813 S. Paca
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME Wm Benson WILLIAM BENSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 1-29-1913

8. AGE: Years	Months	Days	If less than one day
32	1	26	hrs. min.

9. Birthplace: Balto md.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business:
FATHER 12. Name: John F Benson
13. Birthplace: md
MOTHER 14. Maiden name: Lillian Wagner
15. Birthplace: md
16. Informant: Catherine Benson
Address: 813 S. Paca
17. Burial (Burial, cremation, or removal. Which?) Date thereof: MAY 28-45 (month) (day) (year)
Cemetery or crematory: Western Cemetery
Location: Edmonson Avenue
18. Funeral director: John A. Grebliauskas
Address: 423 S. Paca St
19. 5 28 45 Amended
(Date rec'd by registrar) 19.. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25 1945, at 10 30 AM
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 9 1938 to March 25 1945 and that I last saw him alive on March 25 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	11 Yrs
Due to: C V S Fuel	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John G Runkel M. D. or other
Address: Catonsville Md Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

02558

1. PLACE OF DEATH (83a)

County Balto. Registration Dist. No. 32

Village or City Pikesville No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Marie Constance Bentley If U. S. Veteran, specify WAR

(a) Residence: No. Pikesville Md St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	white	widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Robert L Bentley

6. DATE OF BIRTH (month, day, and year) Feb 4 1869

7. AGE	Years	Months	Days	If LESS then 1 day, hrs. or min.
	76	1	27	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore (State or country) Md

FATHER

13. NAME Thomas J Myer

14. BIRTHPLACE (city or town) Balto (State or country) Md

MOTHER

15. MAIDEN NAME Elizabeth Stevens

16. BIRTHPLACE (city or town) Union Mills (State or country) Md

17. INFORMANT R.H.L. Bentley Jr. (Address) Pikesville Md

18. BURIAL, CREMATION, OR REMOVAL Place Leesburg Va. Date Apr 3, 1945 Union Cemetery

19. UNDERTAKER Henry W. Jenkins & Son (Address) McCulloh & Orchard Sts

20. FILED 4/2, 1945 Dr E E Nichols Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Mar (Month) 31 (Dey), 1945 (Yeer)

22. I HEREBY CERTIFY, That I attended deceased from Jan, 1930, to Mar 31, 1945

I last saw h-- alive on Mar 30, 1945; death is said to have occurred on the dete steted above, at 9:30 P m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were es follows:

	Date of onset
Cerebral hemorrhage	3/31/45
Other Contributory Causes of importance:	
arterio sclerosis	1930
Hypertension	1944

Neme of operetion Dete of

Whet test confirmed diegnosis? Was there an autopsy?

23. If deeth wes due to externel ceuses (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Menner of injury

Neture of injury

24. Wes diseese or injury in any way releted to occupation of deceased? No

If so, specify

(Signed) Palmer H Williams M. D.

(Address) Pikesville, Md.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a **clerk.**

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02559

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30yr 9mo. 26days

Hospital, institution, or street address where death occurred:

Spring Grove State Hosp.

How long in hospital or institution? 30Yr 9mo. 26days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2622 Fleet St.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Andrew Bittoff (Biddorf)

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): April 19 1868

8. AGE: Years	Months	Days	If less than one day
76	8	28	....hrs. ....min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: ?

11. Industry or business

FATHER — 12. Name: John Bittoff

13. Birthplace: Germany

MOTHER — 14. Maiden name: Margaret Fleigert

15. Birthplace: Germany

16. Informant: Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 20th (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: City

18. Funeral director: Uellrich Funeral Home

Address: 2004 E. Orleans St

19. 3/22 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17, 1945 at 7:10P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 1937 to Mar. 17 1945

and that I last saw him alive on Mar. 17, 1945

	DURATION
Immediate cause of death: Acute Pulmonary edema	1 day
Due to: Hypertensive cardio-renal vascular disease	Indef.
Due to:	
Other conditions: Decubitus	15 days

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: Robert E. Gardner M.D. M. D. or other

Address: Catonsville, Md. Date signed 3/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

P

02560

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Stoneleigh

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Armacost Nursing Home, Regester Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Stoneleigh

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 6309 Blenheim Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Luella K. Black

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Wilmer Black

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 21, 1861

8. AGE: Years	Months	Days	If less than one day
83	8	14	..... hrs. ..... min.

9. Birthplace: Noblesville, Ind.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: William A. Kinnan

13. Birthplace: Indiana

MOTHER 14. Maiden name: Ethel Linda Pearce

15. Birthplace: Springfield, Ohio

16. Informant: Mr. Robert W. Black

Address: 6309 Blenheim Rd., Stoneleigh

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 8, 1945 (month) (day) (year)

Cemetery or crematory: Lorraine Cemetery

Location: Woodlawn, Md.

18. Funeral director: C. W. Lamoreau

Address: 4510 Liberty Heights Ave.

19. 3/7 19 45 (Date rec'd by registrar) G. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5, 45, at 2.45 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 8 19 44 to March 4 19 45

and that I last saw her alive on March 4 19 45

Immediate cause of death	DURATION
Apoplexy	3 wks
Due to: Arterio-Sclerosis & Hypertension	wks
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John A. Green M. D. or other

Address: Parsonage - md Date signed 3/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Poe .d. U. S.-
3/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 75-d

CERTIFICATE OF DEATH

02561

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Four years

Hospital, Institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? Four years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: 7211 Darthmouth Avenue
(If outside city or town limits, write RURAL and give nearest town)

Street No. College Park
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MILDRED SCOTT BLACK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Walter C. Black

6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): November 1st 1891

8. AGE: Years	Months	Days	If less than one day
53	4	4	....hrs. ....min.

9. Birthplace: Vermont (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER — 12. Name: Leslie Scott

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Ada Richardson

MOTHER — 15. Birthplace: Unknown

16. Informant: Hospital Records -

Address: Catonsville, 28, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof 3/5/45 (month) (day) (year)

Cemetery or crematory:

Location:

18. Funeral director: H. Wyke

Address: 4101 Edmondson Ave

19. 3/6/45 (Date rec'd by registrar) 19 45 Registrar: H. C. Andreae Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5 1945 19 ..., at 2:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1941 19 ..., to March 5 1945 19 ...

and that I last saw her alive on March 5 1945 19 ...

Immediate cause of death	DURATION
Myocardial insufficiency acute	1 week
Due to: Pulmonary infsrct	2 days
Due to: Chronic arteriosclerotic hypertensive heart disease	Indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Henry C. A. Mead M.D.
Henry C. A. Mead, M. D. M. D. or other

Address: Catonsville # 28 Md Date signed: 3/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02562

Reg. Diat. No. 42

1. PLACE OF DEATH:
County: BALTIMORE
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 4307 LEEDS AVENUE
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: BALTIMORE
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No. 4307 LEEDS AVENUE (If rural, give LOCATION)
2.(a) If veteran, name war: NONE

3.(a) FULL NAME: FRANK HOY BLANKNER

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: RUBY "WEBB"
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): MAY 11 1877

8. AGE: Years	Months	Days	If less than one day
67	10	9	hrs. min.

9. Birthplace: BALTIMORE, MARYLAND (Town, county, and state)
10. Usual occupation: PAPER HANGER
11. Industry or business

FATHER
12. Name: JOHN BLANKNER
13. Birthplace: GERMANY

MOTHER
14. Maiden name: ANNA STAHL
15. Birthplace: GERMANY

16. Informant: MRS. RUBY BLANKNER
Address: 4307 LEEDS AVENUE

17. Burial (Burial, cremation, or removal. Which?) Date thereof: MAR. 23, 45 (month) (day) (year)
Cemetery or crematory: LOUDON PARK
Location: FREDERICK AVENUE

18. Funeral director: C. RAYMOND KAUFMAN
Address: 1026 LEEDS AVENUE.

19. Mch 22 45 (Date rec'd by registrar) Geo Kieffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mch 20 19 45, at 8a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 19 to Mch 20 19 45
and that I last saw h[illegible] alive on Mch 20 19 45

	DURATION
Immediate cause of death: Coronary Sclerosis	1 day
Due to: Cardiac Failure	3 yrs.
Due to: Anemia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Geo M. Kieffer M. D. or other
Address: 1420 Mad Blvd Date signed: 3-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B4a)

CERTIFICATE OF DEATH

02563

Reg. Diat. No. 44

1. PLACE OF DEATH:

County Balto.

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

125 Riverside Dr.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto.

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

Street No. 125 Riverside Dr.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles J. Bobart

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 6 - 1889

8. AGE: Years	Months	Days	If less than one day
55	3		..... hrs. ..... min.

9. Birthplace Balto. (Town, county, and state)

10. Usual occupation Tailor

11. Industry or business

FATHER 12. Name Charles Bobart

13. Birthplace Balto.

MOTHER 14. Maiden name Eliz. Edelman

15. Birthplace Balto.

16. Informant Mrs. Frank Bobart

Address 125 Riverside Dr.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/5/45 (month) (day) (year)

Cemetery or crematory Balto. National

Location Frederick Rd.

18. Funeral director John J. Connelly.

Address 418 Eastern Ave. Essex Md

19. 3/2/45 (Date rec'd by registrar) John J. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1st 1945 at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1st 1944 to March 1st 1945

and that I last saw him alive on March 1st 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to	
Due to Hypertension; Arteriosclerosis; Chronic Nephritis.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE James F. White M.D. M. D. or other

Address 7661 Eastern Ave Essex Md Date signed 3/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH (94a)

County Balto. Registration Dist. No. 02533

Village or City Emig. Mills. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Fannie Alfreda Bolton If U. S. Veteran, specify WAR

(a) Residence: No. Emig Mills. Md. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W.	Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ ~~(or)~~ WIFE of Frank C. Bolton

6. DATE OF BIRTH (month, day, and year) Aug 9. 1863

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	7	8	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Balto. (State or country)

FATHER

13. NAME JAMES H. JOHNSON

14. BIRTHPLACE (city or town) Balto. (State or country)

MOTHER

15. MAIDEN NAME ✓

16. BIRTHPLACE (city or town) ✓ (State or country)

17. INFORMANT Mrs F. R. Bolton (Address) Emig Mills. Md.

18. BURIAL, CREMATION, OR REMOVAL Place Loudon Park Date Mch 20, 19 45

19. UNDERTAKER John O. Mitchell & Sons (Address) 1900 Eutaw Place

20. FILED 3/19/45 A. W. Hedgich Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March (Month) 17 (Day) 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan, 1935, to Mar 17, 1945

I last saw h-- alive on Aug 20, 1944, death is said to have occurred on the date stated above, at 8 P m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Coronary occlusion	3/17/45
Other **Contributory Causes** of importance:	
Arterio sclerosis	1925

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any wey releted to occupation of deceased? No

If so, specify

(Signed) Palmer F. C. Williams M. D.

(Address) Pikesville. Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

Rec'd. U.S. 3/19/45

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02565 P

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Balto.
City or town: Lowson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
811 W. Lake Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 811 W. Lake Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: IDA V. BRAINERD

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Edwin A. Brainerd
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 11, 1860

8. AGE: Years	Months	Days	If less than one day
84	11	23	hrs. min.

9. Birthplace: New York, N. Y. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Daniel O. Affleck
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mary Robson
15. Birthplace: Unknown

16. Informant: Mrs. Natalie Doeleman
Address: 811 W. Lake Ave.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3/6/45 (month) (day) (year)
Cemetery or crematory: Fairview Cem.
Location: Westfield, N. J.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 3-5 19 45 A. W. Hedrick per JM. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/4 19 45, at A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on 3/3 19 45 to 3/4 19 45 and that I last saw h. alive on 3/3/45. 19

Immediate cause of death	DURATION
Hemorrhage.	1 day
Due to: Arteriosclerosis.	
Hypertension	25 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. Murray Fisher M. D. or other
Address: 18 E. Eager St. Baltimore 2 Date signed: 3/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

02566

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ~~Baltimore~~

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 719 W. Dover St.,
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I ✓

3.(a) FULL NAME: JOHN BRENT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married--Sep.

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 2, 1867

8. AGE:

Years	Months	Days	If less than one day
78		5	..... hrs. ..... min.

9. Birthplace: Powatown Co., Va.
(Town, county, and state)

10. Usual occupation: ?

11. Industry or business

FATHER
12. Name: ? ?
13. Birthplace ? ?

MOTHER
14. Maiden name: Caroline ?
15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-12-45 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: A. Lee Oder
Address: 4644 York Road., Balto., Md.

19. 3/10 1945 (Date rec'd by registrar) A. W. Hedrick per MN Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8, 1945, at 3:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6, 1945, to March 8, 1945 and that I last saw him alive on March 8, 1945

	DURATION
Immediate cause of death: Uremia, acute	Unknown
Due to: Nephrosclerosis	Unknown
Due to:	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. O'Kenney
C. O'KENNEY, M.D. CLINICAL DIRECTOR
M. D. or other
Address: Fort Howard, Maryland Date signed

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd U.S.
3/10/45

1 Trans

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

CERTIFICATE OF DEATH

02567

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Anneslie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Anneslie
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6518 Maplewood Rd,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ferdinand R. Briele.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs Edith D. Briele.
Nee, Dobler
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 19. 1883

8. AGE: Years	Months	Days	If less than one day
61	9	13	..... hrs. ..... min.

9. Birthplace: Baltimore. Maryland.
(Town, county, and state)
10. Usual occupation: U. S. Post Office
11. Industry or business:

FATHER
12. Name: Henry Briele
13. Birthplace: Baltimore. Maryland.

MOTHER
14. Maiden name: Amelia Kern
15. Birthplace: Baltimore Maryland.

16. Informant: Mrs Edith D. Briele
Address: 6518 Maplewood Rd, Anneslie.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/7/1945 (month) (day) (year)
Cemetery or crematory: Prospect Hill
Location: York Rd, Towson. Md,
18. Funeral director: Howard A. Gill
Address: 19 W. Pennsylvania Ave, Towson. Md.

19. 3/6 19 45 (Date rec'd by registrar) E. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4. 19 45, at 6.30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 1 19 43, to March 4 19 45
and that I last saw h.. alive on February 15 19 45

Immediate cause of death	DURATION
Coronary Occlusion	2 Mos.
Due to: Generalized arteriosclerosis	5 Yrs.
Due to:	
Other conditions: Diabetes Mellitus	4 Yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. S. Chatfield M. D. or other
Address: 6710 York Rd Date signed: March 5, 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-e)

02568

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 318 North East Street

(If rural, give LOCATION)

2.(a) If veteran, name war: --

3.(a) FULL NAME: Louis Brocata

3.(b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	married

6.(b) Name of husband or wife: Edith Guanera

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): October 22, 1875

8. AGE: Years	Months	Days	If less than one day
69	4	9	..... hrs. ..... min.

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: shoemaker

11. Industry or business: own shoemaking

FATHER — 12. Name: Filippo Brocato

13. Birthplace: Italy

MOTHER — 14. Maiden name: Rosalia Dominello

15. Birthplace: Italy

16. Informant: Hospital records

Address: Catonsville, Baltimore - 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-10-45 (month) (day) (year)

Cemetery or crematory: Holy Redeemer cem

Location: 4430 Belair Rd

18. Funeral director: Joseph Farace Inc

Address: 2013 Freemont ave

19. 3/8 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6, 1945 at 9:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 23, 1945, to March 6, 1945 and that I last saw him alive on March 6, 1945

	DURATION
Immediate cause of death: Broncho-pneumonia	3 days
Due to: Subdural hematoma	Indef.
Due to: Automobile accident. Dwlg.	
Other conditions: Fracture of the right leg, compound, comminuted	Indef.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident. Date of 12-16-1944

Where did injury occur? Orleans & Forrest Streets, Baltimore, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Public place.

Means of injury: struck by automobile. Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.

Robert E. Gardner, M.D. M. D. or other

Address: Baltimore - 28, Md. Date signed: 3/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

02569

CERTIFICATE OF DEATH

Reg. Dist. No. 39

1. PLACE OF DEATH:
County Balto
City or town Sparks
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Harry Brown

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Estelle (Nee Haurlle)
6.(c) If alive, give age: 38 years
7. Birth date of deceased (mo., day, yr.): Jan. 6, 1903
8. AGE: Years 42 ~~41~~ Months 1 Days 25 If less than one day ... hrs. ... min.
9. Birthplace: Reynolds, Macon Co., Ga. (Town, county, and state)
10. Usual occupation: Fireman, Penn. RR
11. Industry or business
FATHER 12. Name: John Brown
13. Birthplace: Macon Co., Ga.
MOTHER 14. Maiden name: Unknown
15. Birthplace
16. Informant: Mrs. Harry Brown
Address: 7021 Eutaw Place, Balto Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 8, 1945 (month) (day) (year)
Cemetery or crematory: Ellaville
Location: Macon Co., Georgia
18. Funeral director: Lander M. Brooks
Address: Sparks, Md.
19. 3/4 1945 (Date rec'd by registrar) Anna Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3rd 1945, at 2.45 A M
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from ... 19... to ... 19...~~ ~~and that I last saw h... alive on ... 19...~~

Immediate cause of death: Coronary | DURATION
Due to: Thrombosis
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE W. J. O. MacAuley, M.Ex. M. D. or other
Address: Sykesville, Md.
Date signed: March 3rd 1945

14

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

02570

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:
County: Baltimore
City or town: Cockeysville - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Cockeysville (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Warren Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Laura Virginia Brown

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Joseph L. Brown
8.(c) If alive, give age: deceased years

7. Birth date of deceased (mo., day, yr.): July 25, 1873

8. AGE: Years	Months	Days	If less than one day
71	7	23	hrs. min.

9. Birthplace: Balto. Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Grafton Barnett
13. Birthplace: Balto. Co. Md.
MOTHER 14. Maiden name: Elizabeth Gill
15. Birthplace: Balto. Co. Md.
16. Informant: Mrs. Geo. H. Sheppard
Address: Cockeysville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 23 1945 (month) (day) (year)
Cemetery or crematory: Poplar
Location: Cockeysville, Md.
18. Funeral director: Landon M. Bowles
Address
March 21 45 Wilmer C. Ensor
19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20 1945, at 1 15 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1944, to March 20 1945
and that I last saw her alive on March 20 1945
Immediate cause of death: Coronary Thrombosis (3rd attack) — DURATION: 2 hrs.
Due to: Arteriosclerosis —
Due to: Hypertension
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wilmer C. Ensor M.D.
M. D. or other
Address: Cockeysville Md. Date signed 3/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02571

Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Baltimore
City or town: German Hill Road
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No.: German Hill Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Amelia Bryan.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	col	Married

6.(b) Name of husband or wife: Abrahams
6.(c) If alive, give age: 70 years
7. Birth date of deceased (mo., day, yr.): — — 1876

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	—	—		

9. Birthplace: Back River Md (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business:
FATHER — 12. Name: Abe. ?
13. Birthplace: Md
MOTHER — 14. Maiden name: Emma Cornish
15. Birthplace: Md
16. Informant: Abraham Bryant
Address: German Hill Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-21-45 (month) (day) (year)
Cemetery or crematory: Mt. Auburn Cemetery
Location: Baltimore Md
18. Funeral director: William A Jackson
Address: 916 Penna ave Balto Md.
19. 3/20 1945 (Date rec'd by registrar) Milton McSmulen Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15 1945, at 6 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept - 1944 to March 18 1945
and that I last saw h... alive on March 18 1945
Immediate cause of death: Chronic Mitral Insufficiency — DURATION: unknown
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: P. H. Thomas M.D.
M.D. or other
Address: 1077 N Main St Dundalk Md
Date signed:

M

I

Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

02572 7

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County: Baltimore County
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years
Hospital, institution, or street address where death occurred: 6328 Windsor Mill Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore Co
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6328 Windsor Mill Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Curtis H. Bull

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Georgiana Bull
6.(c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): Nov. 22 1867

8. AGE: Years 77 | Months 3 | Days 24 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Blacksmith & Builder Carriage

11. Industry or business: same

FATHER
12. Name: ? Bull
13. Birthplace: Unknown

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Mrs. Millard S. Bull
Address: 6328 Windsor Mill Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 24 1945 (month) (day) (year)
Cemetery or crematory: Stone Chapel
Location: Balto County, Md.

18. Funeral director: Wm. Cook Sons
Address: Balto, Md.

19. 3/19/45 (Date rec'd by registrar) A. W. Hedrick per M N Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18 1945, at 4:20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 31 1939, to March 18 1945
and that I last saw him alive on March 18 1945

	DURATION
Immediate cause of death: Cerebral Apoplexy	4 days
Due to:	
Due to:	
Other conditions: Myocardial Degeneration	6 yrs

(Include pregnancy within 3 months of death)

Major findings at operations: no Operation
Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Joshua H Armacost MD M. D. or other
Address: 6419 Windsor Mill Rd Balto 7 Md. Date signed: Mar 18 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

#115
#10
#134

Rec'd U.S
3/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

02573

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 hours
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1818 N. Bond St
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Louis Daigan Burke

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 16 1870

8. AGE: Years 75 | Months 1 | Days 9 | If less than one day: hrs. min.

9. Birthplace (Town, county, and state): Baltimore City

10. Usual occupation: Clerk

11. Industry or business: Security Storage & Trust Co.

FATHER
12. Name: Alonzo J. Burke
13. Birthplace: Harford Co, Md

MOTHER
14. Maiden name: Georgia Elizabeth Koch
15. Birthplace: Bulto Co. Md.

16. Informant: Roland T. Burke
Address: 520 Park Ave, Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 12, 1945 (month) (day) (year)
Cemetery or crematory: Greenmount
Location: Baltimore, Md.

18. Funeral director: John Burns Sons
Address: Towson, Md.

19. Mar. 12 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9 1945 at 8 20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8 1945 to March 9 1945 and that I last saw h.. alive on March 9 1945

	DURATION
Immediate cause of death: Cerebral Haemorrhage	30 hours
Due to: Arterio-sclerosis and Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. C. Sellman M.D.
M. D. or other
Address: 600 Baltimore, Towson Md. Date signed: Mar 9 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

02574

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore Point Md.
City or town: Belle.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore Co.
City or town: Harrus Point Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 810 E. A.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edward W. Burkhouse

3.(b) Social Security Number: 213-09-2729

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Catherine
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 18-1891

8. AGE: Years	Months	Days	If less than one day
53			hrs. min.

9. Birthplace: Pittsburg Pa.
(Town, county, and state)
10. Usual occupation: Core Maker.
11. Industry or business: Iron Foundry

FATHER
12. Name: Wm. H. Burkhouse
13. Birthplace: Lexington Va.

MOTHER
14. Maiden name: Victoria Yeakley
15. Birthplace: Pittsburg Pa.

16. Informant: Catherine Burkhouse
Address: 810 E. A.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Mar 10-45 (month) (day) (year)
Cemetery or crematory: Oak Lawn Cem.
Location: Baltimore Md.

18. Funeral director: Wm. A. Adam
Address: 3000 E. Balto St.

19. March 8 1945 (Date rec'd by registrar) Dawson L. Harbes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8-45 19..... at 3 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1- 1945 to March 8 1945
and that I last saw him alive on March 8- 1945

	DURATION
Immediate cause of death: Cardio-Vascular hypertension	6 yrs
Disease	
Due to: Cardiac failure	2 months
Due to: Cardiac hypertrophy	Unknown
Other conditions: Chronic Nephritis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: -
Date of op.
Autopsy results: -
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Dawson L. Harbes M. D. or other
Address: Harrus Point Md. Date signed: 3/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (83-a)

Registered No. [redacted] P 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Catonsville
(b) Street address 5501 Edmonsdon Avenue
(c) Hospital or Institution: Hood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 02575
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5316 Plainfield Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Johanna Butt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Jacob J. Butt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-16-1870

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Bath [illegible] Md (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Unknown John T. Coates
13. Birthplace Unknown Holland

MOTHER
14. Maiden Name Unknown Lidwina Bleng
15. Birthplace Unknown [illegible]

16 (a) Informant Mr. Jacob J. Butt
(b) Address 5316 Plainfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/45 (month) (day) (year)
(c) Cemetery or crematory Saint Joseph's
Location Baltimore County, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) 3/19/45 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 16 1945, at 6 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1945, to Mar 16 1945, and that I last saw h[illegible] alive on Mar 15 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Cerebral Arteriosclerosis	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findinga of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 715 Frederick Rd Date signed 3-17

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47d)

02576

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred: 61 Burke Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 61 Burke Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: -- --------

3. (a) FULL NAME: ESTELLA EDWARDS CALDER

3. (b) Social Security Number: ---------

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: John C. Calder
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): November 11, 1875

8. AGE: Years	Months	Days	If less than one day
69	3	23	--- hrs. --- min.

9. Birthplace: Baltimore Co., Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home
FATHER 12. Name: Charles Edwards
13. Birthplace: Maryland
MOTHER 14. Maiden name: Amanda Edwards
15. Birthplace: Maryland
16. Informant: Robert C. Calder
Address: 61 Burke Ave., Towson, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 9, 1945 (month) (day) (year)
Cemetery or crematory: Trinity Church Cemetery
Location: Long Green, Balto.Co., Md.
18. Funeral director: John Burns' Sons
Address: Towson, Maryland
19. Mar. 9 1945 (Date rec'd by registrar) [illegible signature] Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~February~~ March 6, 1945 at 1:15P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1945, to March 6 1945
and that I last saw her alive on [illegible] 6 1945

Immediate cause of death	DURATION
[illegible] of lung	3 [illegible]
Due to: [illegible]	
Due to: [illegible]	10 [illegible]
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury / Injured at work?

23. SIGNATURE: [illegible signature] M. D. or other
Address: 3201 Garrison [illegible] Date signed: 3/[illegible]

(T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

02577 Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH

County Balto 2nd County

City or town Carney

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 9505 Harford Road

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Baltimore

City or town Carney Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 9505 Harford Road

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME Richard J Casey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sina M Casey

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1868

8. AGE:

Years	Months	Days	If less than one day
76	10	5	hrs. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual occupation Barber

11. Industry or business

FATHER 12. Name James Casey

13. Birthplace Ireland

MOTHER 14. Maiden name Margaret Ward

15. Birthplace Ireland

16. Informant Mrs Sina M Casey (Wife)

Address 9505 Harford Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 15, 1945 (month) (day) (year)

Cemetery or crematory London Park Cemetery

Location Frederick Road Balto Md

18. Funeral director Albert L Hilt Jr

Address 1606 N Chester Street

19. 3/13 1945 H. W. Hebert Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1945, at 7p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/14/45 to 3/11 1945

and that I last saw h- alive on Mar 10 1945.

Immediate cause of death Cardiac failure

Myocarditis, acute, DURATION 18 days

Due to Duration two months

Due to Senility, atheroma

Other conditions Bronchitis ?

Asthma

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Neil MacMurchy MD

M. D. or other

Address 1716 Normal Ave Date signed

Balto. Md

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02578 Reg. Dist. No. 47

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred: Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)

State: Maryland County: ~~Baltimore~~

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2741 Rayner Ave., Balto., Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: ~~World War I~~

3.(a) FULL NAME: CLEMENTS, Paul James

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edna Clements — 6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): October 6, 1890

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
54	4	27		

9. Birthplace: Oella, Maryland (Town, county, and state)

10. Usual occupation: Cloth Inspector

11. Industry or business:

FATHER — 12. Name: James Clements

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Ella Bryan

15. Birthplace: Maryland

16. Informant: Clinical Records

Address: Vets. Adm. Fac., Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3.7.45 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: 3901 Fredrick Rd

18. Funeral director: Harry K. Wilkes

Address: 4101 E Monument Ave

19. 3/7 45 (Date rec'd by registrar) A. W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4 19 45 at 10:40 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 19 45 to March 4 19 45 and that I last saw him alive on March 4 19 45

Immediate cause of death	DURATION
TB chr. pul. Far advanced	1 yr plus
Due to	
Due to	
Other conditions: Hemorrhoids, ext. Malnutrition	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? No

23. SIGNATURE: C. J. Kenney M. D. or other

Address: ..... Date signed: .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd from U.S.
3/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124a)

CERTIFICATE OF DEATH

02579

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs., 2 mos., 23 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 3 yrs., 2 mos., 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 929 Valley Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Clift (Mary Elma)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: William T. Clift

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 27, 1888

8. AGE: Years	Months	Days	If less than one day
56	5	2	hrs. min.

9. Birthplace: Andrews, South Carolina (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: William S. Camlin

FATHER — 13. Birthplace: Andrews, South Carolina

MOTHER — 14. Maiden name: Mary Ella Avant

MOTHER — 15. Birthplace: Andrews, South Carolina

16. Informant: Hospital records

Address: Catonsville, Balto.-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-20-45 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Md.

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Md.

19. 3/20 45 (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1 19 45 at 12:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 6 19 41, to March 1 19 45

and that I last saw her alive on March 1 19 45

	DURATION
Immediate cause of death: Terminal broncho pneumonia	24 hours
Due to: Chr. myocardial insufficiency	Indef.
Due to: Cirrhosis, Laennec's	"
Other conditions: Splenomegaly	"

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner, M.D. M. D. or other

Address: Catonsville, Balto.-28, Md. Date signed: 3/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02580

Reg. Diat. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson, 4 Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since March 5, 1943
Hospital, institution, or street address where death occurred: Eudowood Sanatorium Towson, Md.
How long in hospital or institution? Since March 5, 1943

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: City, Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1021 N Washington St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Elizabeth Anna Corkran

3. (b) Social Security Number: 215-14-0373

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Vernon W Corkran
6.(c) If alive, give age: 28 years
7. Birth date of deceased (mo., day, yr.): August 28, 1919
8. AGE: Years: 25 Months: 6 Days: If less than one day: hrs. min.
9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Frank O'Hara
13. Birthplace: Baltimore Md
MOTHER 14. Maiden name: Carrie Schantle
15. Birthplace: Baltimore Md
16. Informant: Personal History, Hospital Records
Address: Eudowood Sanatorium, Towson, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3 23 45 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Baltimore
18. Funeral director: Philip Herwig Sons
Address: 2024 Orleans St
19. 3/24 1945 CT (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19 1945 at 11:25 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1943, to March 19 1945 and that I last saw h.. alive on March 19 1945

	DURATION
Immediate cause of death: Pulmonary tuberculosis	
Due to:	Since about March 1941
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William A Bridgett M. D. Other
Address: Towson, 4, Maryland Date signed: 3-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Card came in
from Edmund
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02581

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: 2704 Glendale Rd Parkville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Hannah Elizabeth Cochran

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Wm Cochran
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 14 - 1865

8. AGE:

Years	Months	Days	If less than one day
79	4	24	..... hrs. ..... min.

9. Birthplace: Rutledge Harford Co Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Colin T Dalton
13. Birthplace: Ireland
MOTHER 14. Maiden name: Catherine Kelley
15. Birthplace: Ireland
16. Informant: Mrs Clara Isenock
Address: 2704 Glendale Rd Parkville
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 14 1945 (month) (day) (year)
Cemetery or crematory: St Johns Emmorton
Location: Long Green Balto Co Md
18. Funeral director: Martin G Kurtz
Address: Jarrettsville Md
19. Mar 11 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11, 1945 at 2 30 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 11, 1945, to March 11 1945
and that I last saw h.. alive on March 11, 1945

Immediate cause of death	DURATION
Coronary thrombosis	
Due to	1 day
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. A. Groot, M.D.
M.D. or other
Address: 8100 Harford Rd Date signed: 3/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. Trans.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-E)

CERTIFICATE OF DEATH

02582

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54 days

Hospital, institution, or street address where death occurred:
Fort Howard, Maryland V. A. F.

How long in hospital or institution? 54 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County ~~Baltimore~~

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3112 Keswick Rd., Baltimore, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war WW-I

3.(a) FULL NAME

Michael Joseph Covahey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Elsie Covahey

6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 4/18/94

8. AGE: Years	Months	Days	If less than one day
50	11	13	...hrs. ...min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name John Covahey
13. Birthplace Ireland

MOTHER
14. Maiden name Mary McNeeve
15. Birthplace Ireland

16. Informant Clinical Records
Address V.A.F., Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-7-45 (month) (day) (year)

Cemetery or crematory Baltimore National

Location Eastern Ave.

18. Funeral director A. Lee Oder

Address 4644 York Rd., Baltimore, Md.

19. 3/6 (Date rec'd by registrar) 19 45 A. D. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 19 45, at 2:55 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 10 19 45, to March 4 19 45

and that I last saw h...im...alive on March 4 19 45

Immediate cause of death	DURATION
BRONCHOGENIC CARCINOMA LEFT LUNG	4 mo. plus
Due to	
Due to	
Other conditions Bronchitis, chronic	
TB chr. pul minimal arrested	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

02583 Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore County
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Mrs. Hoods Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1633 N. Wolfe St.
(If rural, give LOCATION)
2.(a) If veteran, name war: No.

3.(a) FULL NAME: MARY HAMILTON COWMAN

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: George Washington Cowman
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 2, 1857

8. AGE: Years	Months	Days	If less than one day
87	10	28	hrs. min.

9. Birthplace: Baltimore, Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Henry Hamilton Durkee
13. Birthplace: Baltimore, Md

MOTHER
14. Maiden name: Julia Marfield
15. Birthplace: Maryland

16. Informant: Mr. Wilbur Cowman
Address: 510 N. Highland Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-31-45 (month) (day) (year)
Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Maryland

18. Funeral director: HENRY SANDER & SONS, INC.
Address: NORTH AVE. & BROADWAY

19. 3/30 19 45 (Date rec'd by registrar) H. C. Andrese Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 19 45, at 1209 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 19 45 to Thur 30 19 45
and that I last saw h... alive on Mar 30 19 45

	DURATION
Immediate cause of death: Cerebral Hemorrhage	3 days
Due to: Cerebral Arterio Sclerosis	
Due to:	
Other conditions: Colon Infection Ovarian Cyst	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Date signed: 3-30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131?)

02584

CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Baltimore
City or town Catonsville (If outside city or town limits, write RURAL and give nearest town)
Street No. 39 Wade Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Margaret E Cullen
3.(b) Social Security Number

4. Sex Female | 5. Color or race White | 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Sept 20, 1864

8. AGE: Years 80 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Alexandria Va (Town, county, and state)
10. Usual occupation none
11. Industry or business

FATHER
12. Name John Cullen
13. Birthplace Ireland

MOTHER
14. Maiden name Eliza Kerwin
15. Birthplace Ireland

16. Informant Mrs Annie T Riordan
Address 39 Wade Ave Catonsville Md

17. Burial Date thereof 3/14/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory New Cathedral
Location Baltimore Md

18. Funeral director William Cook Inc
Address 1217 St Paul St

19. 3/12 19 45 (Date rec'd by registrar)
Registrar [signature] Deputy Reg

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 19 45, at 1:06 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1-14 19 41 to 3-11 19 45
and that I last saw her alive on 3-10 19 45

Immediate cause of death	DURATION
Nephritis	2 weeks
Due to Cardio-Vascular Renal Dis	5 yrs?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George Ellison MD
M. D. or other
Address 803 Frederick Ave Catonsville 28 Md
Date signed 3-11-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

02585

CERTIFICATE OF DEATH

Reg. Diat. No. 41

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk - Rr. Ind.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 YEARS
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD. County: BALTO.
City or town: DUNDALK
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 133 VENTNOR TERRACE
(If rural, give LOCATION)
2.(a) If veteran, name war: NO

3.(a) FULL NAME: ANNA Louise DAVIS.

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	DIVORCED

6.(b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.): MAY 24 1885 6.(c) If alive, give age: years

8. AGE: Years	Months	Days	If less than one day
59	10	5	hrs. min.

9. Birthplace: FLORIDA
(Town, county, and state)

10. Usual occupation: HOUSE WIFE

11. Industry or business: AT HOME

FATHER
12. Name: ? McWILLIAM
13. Birthplace: UNKNOWN

MOTHER
14. Maiden name: UNKNOWN
15. Birthplace: UNKNOWN

16. Informant: JUANITA McLYMAN (DAUGHTER)
Address: 133 VENTNOR TERRACE DUNDALK MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: MAR. 31/45 (month) (day) (year)
Cemetery or crematory: SCHWARTZ
Location: ODONNELL ST.

18. Funeral director: Seba & Zeale Co.
Address: 403 S. WOLFE ST.

19. March 29 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29th 19 45 at 7 1/2 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
(a) Coronary Occlusion	15-30 m.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: ... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: M B Davis M.D.
(M. D., or other)
Address: ... Date signed: 3/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

02586

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:
County: Baltimore
City or town: White Hall.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: White Hall. R F D
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: James B. Davis

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Mary E Davis
6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Nov. 29 1857

8. AGE: Years	Months	Days	If less than one day
87	3	18	...hrs. ...min.

9. Birthplace: Pa.
(Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business
FATHER 12. Name: John Davis
FATHER 13. Birthplace: Pa
MOTHER 14. Maiden name: Anne Rawson
MOTHER 15. Birthplace: Pa
16. Informant: Mrs Mary E Davis
Address: White Hall. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 19-1945 (month) (day) (year)
Cemetery or crematory: West Liberty
Location: White Hall. Md
18. Funeral director: Howard S. Marbline
Address: White Hall. Md
19. March 19 1945 (Date rec'd by registrar) Mrs Howard S. Marbline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 17 1945 at 9:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 1 1945, to Mar. 17 1945
and that I last saw h[im] alive on Mar. 16 1945

Immediate cause of death	DURATION
Uremia	
Due to	
Due to	
Other conditions: Chronic nephritis; Chronic hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. M. Frame M. D. or other
Address: Parkton, Md Date signed: 3/19/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING (INK). Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33a)

02587 7

CERTIFICATE OF DEATH

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Lodge Forest

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 7006 Bay Front Rd.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Lodge Forest Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 7006 Bay Front Rd.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Antonina Demski

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife: Leonard

6(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): June 29 / 1890

8. AGE: Years: 54 Months: 9 Days: If less than one day: hrs. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER 12. Name: Sochi

13. Birthplace: Poland

MOTHER 14. Maiden name: unknown

15. Birthplace: Poland

16. Informant: Mr. Leonard Demski

Address: 7006 Bay Front Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 / 23 / 45 (month) (day) (year)

Cemetery or crematory: Holy Rosary Cem

Location: German Hill Road.

18. Funeral director: Stephen J. Fratkowski, Jr.

Address: 1000 S. Kenwood Ave

19. 3/24 1945 C. W. Hedrich Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19 1945; at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1942, to March 19 1945, and that I last saw her alive on March 19 1945.

Immediate cause of death: Cerebral Hemorrhage — DURATION: 5 hours

Due to: Malignant Hypertension — 3 years

Due to: Disease

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dawson L. Harbes M. D. or other

Address: Sparrows Point, Md. Date signed: 3/20/45

Rec'd. U.S.
3/21/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

02588

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 28 Belgrave Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME George Klitzel

3.(b) Social Security Number

4. Sex: M. | 5. Color or race: W. | 6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: Cath Kate Smith Klitzel

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 29, 1858

8. AGE: Years: 86 | Months: 4 | Days: 10 | If less than one day: hrs. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Farmer

FATHER
12. Name: Frederick Klitzel
13. Birthplace:

MOTHER
14. Maiden name: —
15. Birthplace: —

16. Informant: Mrs. Marie Klitzel
Address: 28 Belgrave Rd Cat.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/13/45 (month) (day) (year)
Cemetery or crematory: Trinity Evangelical Lutheran Ch.
Location: Harford Co. Md.

18. Funeral director: Harry H. Mitzke
Address: 401 Edmondson Ave

19. 3/13 (Date rec'd by registrar) 1945 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10/45 19 at 3:38 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 15 1944, to Mar 10 1945 and that I last saw h.im alive on Mar 10 1945

	DURATION
Immediate cause of death: Cerebral arterio-sclerosis	7
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Carl P. Rossiter M. D. or other
Address: 1316 W Lombard St Date signed: 3/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Mr. Raetting
1324 W. Lombard
St.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

Reg. Dist. No. 02589 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 7906 Ardmore Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Philip Doeller

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Julia Messinger

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 26, 1864

8. AGE: Years	Months	Days	If less than one day
80	7	17	hrs. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Not Known
13. Birthplace: " "

MOTHER
14. Maiden name: Kapple
15. Birthplace: not known

16. Informant: George Doeller
Address: 250 S. East Ave.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 3/19/45
(month) (day) (year)

Cemetery or crematory: Oak Lawn

Location: Eastern Ave.

18. Funeral director: Clarence F. Hoffmann

Address: 1639 N. Broadway

19. 3/19/45 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15 19 45 at 7.16P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 19 45 to March 15 19 45 and that I last saw h... alive on March 15 19 45

	DURATION
Immediate cause of death: Coronary Thrombosis	11 days
Due to: Generalized arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D.
M. D. or other

Address: 621 Hanford Rd Date signed: 3/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd U.S.
3/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

02590 P

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland
How long in hospital or institution? 18 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: QA
City or town: Love Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. Love Point, Maryland
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I ✓

3. (a) FULL NAME: GEORGE J. ERHARDT

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ollie Erhardt
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): 6-18-98

8. AGE: Years	Months	Days	If less than one day
46	8	23	...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Retired Policeman
11. Industry or business

FATHER
12. Name: Lorenz ERHARDT
13. Birthplace: ? BALTO. MD.

MOTHER
14. Maiden name: Jennie DOERFLER
15. Birthplace: ? BALTO. MD.

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: MAR. 19/45 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: Lilly & Zeiler Inc.
Address: 403 S. Wolfe St., Balto., Md.

19. 3/16 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14, 1945, at 5:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 24, 1945, to March 14, 1945 and that I last saw him alive on March 14, 1945

Immediate cause of death	DURATION
Disease of the Heart	
Rheumatic Fever, myocardial damage	
Myocardial Insufficiency	3 Yrs. plus
Due to	
Due to	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none ...Date of op.
Autopsy results: not done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. J. KENNEY, M.D. CLINICAL DIRECTOR M. D. or other
Address: Ft. Howard, Maryland Date signed: 3-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02591

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 10 months, 26 days

Hospital, institution, or street address where death occurred:
Sping Grove State Hospital

How long in hospital or institution? 1 year, 10 months, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1151 West Cross Street
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Isabelle Fleischer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: William Fleischer

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): September 1, 1881

8. AGE:	Years	Months	Days	If less than one day
	63	6	22	....hrs. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: home

FATHER
12. Name: John Weiss
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Joan Hillery
15. Birthplace: Baltimore, Md.

16. Informant: Hospital Records

Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/27/45 (month) (day) (year)

Cemetery or crematory: New Cathedral Cem.

Location: 4300 Old Frederick Road

18. Funeral director: John J. Cowan & Son

Address: 96-03 Gallows Street

19. 3/26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 19 45 at 6:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25, 1942 19 , to March 22 19 45 and that I last saw her alive on March 22 19 45

Immediate cause of death	DURATION
Terminal pneumonia	3 days
Due to: Chronic Myocarditis	Indef.
Due to: Generalized arteriosclerosis.	Indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robert E. Gardner M. D. or other
Address: Catonsville-28, Md. Date signed: 3/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-9)

CERTIFICATE OF DEATH

02592

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Knights of Columbus, Madison & Cathedral

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: GEORGE J. FRANK

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Widowed

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 12-20-1890

8. AGE: Years	Months	Days	If less than one day
54	2	10	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Real Estate Business

11. Industry or business: See above

FATHER — 12. Name: Henry Frank

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Jennie Schmidt

MOTHER — 15. Birthplace: Germany

16. Informant: Clinical Records, Vets. Adm. Fac.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 6, 1945 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: John A. Moran

Address: York Road., Baltimore, Md.

19. 3/5 (Date rec'd by registrar) 19 45 R.W. Heldel D.M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3, 1945, at 4:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 27, 1945 to March 3, 1945 and that I last saw h.im alive on March 3, 1945

Immediate cause of death	DURATION
Carcinoma of Pancrease with metastasis to liver	5 Mos. Plus
Due to	
Due to	
Other conditions: Healed G.S.W. right arm & right hip, below heart non-symptomatic	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? Mm

23. SIGNATURE: C.J. KERNEY, M.D. CLINICAL M. D., or other TOR

Address: Fort Howard, Maryland Date signed: 3-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

02593

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years, 11 months, 24 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 6 years, 11 months, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1007 Forrest Street
(If rural, give LOCATION)

2.(a) If veteran, name war --

3.(a) FULL NAME Willie Fugate

3.(b) Social Security Number --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	separated

6.(b) Name of husband or wife Sadie Lowenstein

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 7, 1871

8. AGE:	Years	Months	Days	If less than one day
	73	8	21	...hrs. ...min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation junk collector

11. Industry or business himself

FATHER
12. Name James P. Fugate
13. Birthplace Maryland

MOTHER
14. Maiden name Mary Catherine Barnhart
15. Birthplace Maryland

16. Informant Hospital records

Address Catonsville, Baltimore- 28, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 4-19-45 (month) (day) (year)

Cemetery or crematory Spring Grove State Hospital

Location Catonsville 28, Maryland

18. Funeral director Spring Grove State Hospital

Address Catonsville 28, Maryland

19. 4/19/45 (Date rec'd by registrar) H. C. Andreae Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1945, at 10:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4, 1938, to March 28, 1945 and that I last saw him alive on March 28, 1945

Immediate cause of death	DURATION
Chronic myocardial insufficiency	2 mths
Due to Chronic cardiovascular disease	
Due to with arteriosclerosis	indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Robert E. Gardner M.D.
Robert E. Gardner, M.D. M. D. or other

Address Baltimore - 28, Md. Date signed 3/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Please write the causes of death clearly and legibly.

VS A15

STATE
~~BALTIMORE CITY~~ HEALTH DEPARTMENT

CERTIFICATE OF DEATH (40-2)

Registered No. 44
02594

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore ~~City~~, Maryland
(b) Street address 5047 Orville Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Armstead Gardens
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5047 Orville Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Galuska

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8-1889

8. AGE: Years	Months	Days	If less than one day
55	10	5	hr. min.

9. Birthplace VA
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Riley Griffin
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace VA

16 (a) Informant George Galuska
(b) Address 5547 Orville Ave

17 (a) Hamit (Burial, cremation, or removal) (b) Date thereof 3/14/45 (month) (day) (year)
(c) Cemetery or crematory Durbin Cem
Location Durbin Wy VA.

18 (a) Funeral director Wm Cook Inc
(b) Address 1317 St Paul St

19 (a) 3/14/45 (Date rec'd by registrar) (b) A. W. Hedrich per MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1945, at 1:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945, to March 13 1945, and that I last saw h.. alive on March 13 1945.

Immediate cause of death	Duration
Lympho Sarcoma.	4 yrs.
Due to Primary in intestines ? ? ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Coral Gordon M. D.
Address 2201 W. North Ave Date signed 3-13-45

VS 150

Rec'd. U.S. 3/14/45

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline **that particular ONE** cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-G)

CERTIFICATE OF DEATH

02595

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 22 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 3 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3606 Brooklyn Avenue
(If roral, give LOCATION)

2.(a) If veleran, name war: --

3. (a) FULL NAME

Annetta Gesser

3. (b) Social Security Number

--

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	married

6.(b) Name of husband or wife: George V. Gesser

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): April 30, 1907

8. AGE: Years	Months	Days	If less than one day
37	10	--	..... hrs. ..... min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: home

FATHER
12. Name: William Deeter
13. Birthplace: unk.

MOTHER
14. Maiden name: Pearl (Yates) Fasick
15. Birthplace: Pennsylvania

16. Informant: Hospital records

Address: Catonsville, Baltimore - 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof ? (month) (day) (year)

Cemetery or crematory: Altoona Pa.

Location: altoona pa.

18. Funeral director: John M. Weber

Address: 461 S. Chester Street

19. 3/3 19 45 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2, 1945, at 3:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 8, 1944, to March 2, 1945 and that I last saw h...er...alive on March 2, 1945

Immediate cause of death	DURATION
Myocardial failure	1 month
Due to: General paresis	Indef.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: Robert E. Gardner, M.D.
Robert E. Gardner, M.D. M. D. or other

Address: Baltimore - 28, Md. Date signed: 3/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

62596 P

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 118 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 118 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ~~Baltimore~~

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 414 Myrtle Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW

3.(a) FULL NAME: HENRY W. GHEE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mary Ghee

6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): July 15, 1896

8. AGE: Years	Months	Days	If less than one day
48	7	26	....hrs. ....min.

9. Birthplace: Chase City, Virginia
(Town, county, and state)

10. Usual occupation: Bar Tender

11. Industry or business:

FATHER — 12. Name: John Ghee
13. Birthplace: Virginia

MOTHER — 14. Maiden name: Ellie Pollard
15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/19/45 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: Elroy C. Wilson
Address: 1000 Brantley Ave., Balto., Md.

19. 3/17/45 (Date rec'd by registrar) 19.... A.W. Redmond Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14, 1945, at 10:55A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 16, 1944, to March 14, 1945 and that I last saw him alive on March 14, 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	4 Hrs.
Due to: Syphilis, latent	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. C. KENNEY, M.D. CLINICAL DIRECTOR M. D. or other

Address: Fort Howard, Maryland Date signed: 3-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02597

Reg. Diat. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 5 mos., 24 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 1 yr., 5 mos., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2423 E. Lanvale Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: John Graddick

3. (b) Social Security Number: No. Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Separated

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 21, 1903

8. AGE: Years	Months	Days	If less than one day
41	8	1	hrs. min.

9. Birthplace: South Carolina (Town, county, and state)
10. Usual occupation: Iron Worker
11. Industry or business

FATHER
12. Name: John Graddick
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Florence Broom
15. Birthplace: South Carolina

16. Informant: John Graddick
Address: 2423 E. Lanvale St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 23, 1945 (month) (day) (year)
Cemetery or crematory: Moreland Memorial Park
Location: 5806 Harford Rd., Balto., Md.

18. Funeral director: John C. Miller, Inc.
Address: 2433 E. Oliver St., Balto., Md.

19. Mar. 22, 1945 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22, 1945, at 7:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 26, 1943, to March 22, 1945 and that I last saw him alive on March 22, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 yrs.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Tuberculous Laryngitis	9 mos.

(Include pregnancy within 3 months of death)

Major findings at operations:
Date of op.:
Autopsy results: No autopsy.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Stewart A. Shaffer M.D.
M. D. or other
Address: Mount Wilson, Md. Date signed: 3/22/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

02598

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
Street No. 25 Bishops Lane (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Grim

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Henry
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 4 1872

8. AGE: Years: 72 | Months: 7 | Days: 4 | If less than one day: hrs. min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Patrick Courtney
13. Birthplace: Ireland

MOTHER
14. Maiden name: Not Known
15. Birthplace: Ireland

16. Informant: Miss Margaret Grim
Address: 25 Bishops Lane

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-10-45 (month) (day) (year)
Cemetery or crematory: Cathedral
Location: Baltimore Md

18. Funeral director: George A. Fahey
Address: Catonsville Md

19. 3/9 1945 (Date rec'd by registrar) H. C. Andrews Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March, 8 19 45, at 7:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October, 25 19 36 to March, 8 19 45
and that I last saw her alive on March, 6, 19 45

Immediate cause of death	DURATION
Chronic Myocarditis.	9 yrs.
Due to	
Obesity.	
Due to	
Other conditions: O	

(Include pregnancy within 3 months of death)

Major findings of operations: O
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: O Date of:
Where did injury occur? O (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: V Injured at work?

23. SIGNATURE: D. Lloyd Johnson M. D. or other
Address: Catonsville, Md. Date signed: 3-9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-E)

CERTIFICATE OF DEATH

02599

Reg. Diat. No. 44

1. PLACE OF DEATH

County: Baltimore

City or town: 104 Walnut Ave, Dundalk 22 Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto -

City or town: 104 Walnut Ave.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Dundalk 22 Md

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Helen alma Guthrie

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C.	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 11, 1915

8. AGE:	Years	Months	Days	If less than one day
	29	5	4	..... hrs. ..... min.

9. Birthplace: Steelton, Penna. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER

12. Name: Charles H. Guthrie

13. Birthplace: Va.

MOTHER

14. Maiden name: Sallie Terrell

15. Birthplace: Penna.

16. Informant: Mrs. Sallie Guthrie

Address: 104 Walnut Ave. Dundalk, Md.

17. ~~Burial~~/Interment Date thereof 3-19-45 (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location: Steelton, Penna.

18. Funeral director: Jesse W. Redden

Address: 436 W. Biddle St.

19. March 16 1945 John O. Connelly Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15th 1945 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2 - 1945 to March 15th 1945 and that I last saw h[illegible] alive on March 15th 1945

Immediate cause of death	DURATION
Chronic Mitral Insufficiency	Indefinite
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: None Injured at work?

23. SIGNATURE: J. H. Thomas M.D. M. D. or other

Address: 107 N. Main St., Dundalk 22 Md. Date signed 3/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

02600 30

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Nine years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No.: 5413 Old Frederick Road
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Melvin G. Guttromson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Beatrice Guttromson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 2, 1914

8. AGE: Years	Months	Days	If less than one day
31	1	22	hrs. min.

9. Birthplace: Esmond, North Dakota (Town, county, and state)
10. Usual occupation: Social Security Board
11. Industry or business: U. S. Government

FATHER
12. Name: Olaf Guttromson
13. Birthplace: Minnesota

MOTHER
14. Maiden name: Anna Gullickson
15. Birthplace: Norway

16. Informant: Mrs. Beatrice Guttromson
Address: 5413 Old Frederick Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 28. 45 (month) (day) (year)
Cemetery or crematory: London Park
Location: Baltimore Md.
18. Funeral director: Frank H. Seitz
Address: 814 N 36 St

19. 3/27 19 45 [illegible] (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24th. 19 45 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 25, 19 44 to March 24th. 19 45 and that I last saw h... im ...alive on March 24, 19 45

Immediate cause of death: Melano sarcoma ; of skin. cut.or. — DURATION

Due to Patient had melanotic mole removed by Army in 1942. Another operation done by

Due to Army, in August, 1944. Following removal of this mole he developed multiple lesions

Other conditions of melano-sarcoma.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. W. Kupp M. D. or other
Address: 3030 Edmondson Ave. Date signed: 3/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12-a)

02601

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)
Street No. Bowleys Quarters Road
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: John H Guy

3.(b) Social Security Number: 220-22-1133

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 14th. 1928

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
16	7	17		

9. Birthplace: Ewell Island, Maryland (Town, county, and state)
10. Usual occupation: Machine Operator
11. Industry or business: American Can Co.

FATHER
12. Name: John R. Guy
13. Birthplace: Ewell Island, Maryland

MOTHER
14. Maiden name: Gaynell Tyler
15. Birthplace: Ewell Island, Maryland

16. Informant: Mr. John R. Guy
Address: Bowleys Quarters Road, Middle River

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 4th. 1945 (mouth) (day) (year)
Cemetery or crematory: Ebenezer Methodist
Location: Chase, Maryland

18. Funeral director: Lassahn Funeral Home
Address: 7401 Belair Road

19. 3/2/45 (Date rec'd by registrar) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1st. 1945 at 2 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 25 1945 to Mar. 1. 1945 and that I last saw him alive on Mar 1 1945

Immediate cause of death	DURATION
Hemmorrhage	
Due to: Hepatitis	
Due to: Cholangitis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul R. Estep M D (M. D. or other)
Address: 5 to Middle River Rd Balto 20 Date signed: 3/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-C)

CERTIFICATE OF DEATH

PC 02602 P

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Balto.

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Mercy Villa

Hospital, Institution, or street address where death occurred: Bellona Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 209 W. Lanvale St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JOSEPHINE LISTON HACKETT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William J. Hackett

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 27, 1897

8. AGE: Years	Months	Days	If less than one day
48	1	4	hrs. min.

9. Birthplace: Cambridge, Mass. (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Edward Liston

13. Birthplace: Boston, Mass.

MOTHER — 14. Maiden name: Mary Seabury

15. Birthplace: Boston, Mass.

16. Informant: Mr. William J. Hackett

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/2/45 (month) (day) (year)

Cemetery or crematory: Cambridge Cem.,

Location: Cambridge, Mass.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 4/2 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31, 1945, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 44, to March 31 19 45 and that I last saw h[illegible] alive on March 31 19 45

	DURATION
Immediate cause of death: Internal hemorrhage	3 days
Due to: Carcinoma of stomach	3 yrs. (?)
Tumors of abdomen	1½ yrs. (?)
Due to:	
Other conditions: Pathological fracture of neck of femur	

(Include pregnancy within 3 months of death)

Major findings of operations: Resection 1/3 stomach abt 3 yrs ago for carcinoma; Gastroenterostomy 1½ yrs ago Date of op.

Autopsy results: not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jno A Hinkel M. D. or other

Address: 122 Eager St Date signed: Apr 2 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

Rev. John A. Luetscher-
12 E. Roger St.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (468) Reg. Dist. No. 31

CERTIFICATE OF DEATH

02603

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:

(a) County Baltimore

(b) City or town Randallstown (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Green Lane

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Randallstown (If outside city or town limits, write RURAL and give town)

(d) Street No. Green Lane (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Katherine B. Hagenrater

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Henry C. Hagenrater

6. (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) October 28, 1882

8. AGE: Years	Months	Days	If less than one day
62	4	26	____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name William S. Seeley

13. Birthplace Maryland

MOTHER

14. Maiden Name Harriett A. Peregoy

15. Birthplace Washington, D. C.

16 (a) Informant Mr. Henry C. Hagenrater

(b) Address Green Lane, Randallstown

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 26, 1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Olive Cemetery

Location Roslyn, Md.

18 (a) Funeral director Millard Lawrence

(b) Address 4510 Liberty Heights Ave.

19 (a) 1/24/45 (Date rec'd by registrar) (b) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. Date of death March 24 1945, at 4.30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 23 1945 to Mar 24 1945, and that I last saw him alive on Mar 23 1945.

Immediate cause of death	Duration
Carcinoma of Stomach with perforation and peritonitis	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Wm. E. Martin M. D. or other

Address Randallstown Date signed 1/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-B)

CERTIFICATE OF DEATH

02604

Reg. Diat. No. 31

1. PLACE OF DEATH:

County: Baltimore

City or town: Randallstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

Randallstown

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Randallstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Stoney Brook Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Louise Anderson Hargreave

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Arthur C. Hargreave

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Mar. 6 1897

8. AGE:

Years	Months	Days	If less than one day
48	0	10	..... hrs. ..... min.

9. Birthplace: Baltimore Md.

(Town, county, and state)

10. Usual occupation: H-W-

11. Industry or business: at home

FATHER

12. Name: Charles H. Anderson, Sr

13. Birthplace: Maryland

MOTHER

14. Maiden name: Minnie E. Aumwell

15. Birthplace: Maryland

18. Informant: Arthur Hargreave

Address: Randallstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/14/45 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville Md

18. Funeral director: John E. Mitchell & Son

Address: 1900 Eutaw Place

19. 3/14/45 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 11 1945 at 7:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940 to Mar. 11, 1945

and that I last saw h... alive on Mar 11 1945

Immediate cause of death: chronic nephritis — DURATION: 5

Due to:

Due to:

Other conditions: Chronic Hot Flashes with decompensation

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other

Address: Randallstown Date signed 3/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

02605

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:

County Baltimore

City or town Owings Mills - Rural
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Lifetime

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Owings Mills - Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Green Spring Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME Anna Elizabeth Harris

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6 (b) Name of husband or wife William J. Harris

6(c) If alive, give age 91+ years

7. Birth date of deceased (mo., day, yr.) June 17, 1858

8. AGE:

Years	Months	Days	If less than one day
86	9	19	____hrs. ____min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Joshua Mayes
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden name Dorcas Moffit
15. Birthplace Balto. Co. Md.

16. Informant Mrs. Clarence Robinson

Address Owings Mills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 3, 1945 (month) (day) (year)

Cemetery or crematory David Ridge Cem.

Location Pikesville, Md.

18. Funeral director Landon M. Brooks

Address Sparks, Md.

19. Apr. 2 (Date rec'd by registrar) 18. 45 Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31/45 19____, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/1/36 19____, to 3/31/45 19____, and that I last saw her alive on 3/31/45 19____.

Immediate cause of death	DURATION
Cerebral hemorrhage	1 wk
Due to hypertension	34 yrs
Due to Arteriosclerosis	?
Other conditions Diabetes	10 yrs

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James L. Sadtler M. D. or other

Address Reisterstown, Md. Date signed 3/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

02606

Reg. Dist. No. 41

1. PLACE OF DEATH:

County: Balto

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred: 19 Northbridge Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 19 Northbridge Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William J Harrison

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Cassie E Harrison

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 25 1865

8. AGE: Years	Months	Days	If less than one day
79			....hrs. ....min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Steel Worker

11. Industry or business: Retired

FATHER — 12. Name: Frank Harrison

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Margaret Lowery

MOTHER — 15. Birthplace: Md

16. Informant: Wm J Harrison

Address: Jonestown Pa

17. (Burial, cremation, or removal. Which?) Burial Date thereof March 14 45 (month) (day) (year)

Cemetery or crematory: Parkwood Cem

Location: Rural

18. Funeral director: Geesie Funeral Home

Address: 2004-8 Orleans St

19. 3/10/45 19.... Wm Clearance Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10 1945, at 3 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 1945, to March 10 1945

and that I last saw h alive on March 8 1945

Immediate cause of death	DURATION
(a) Asthenia - Exhaustion	5 days
Due to (b) Carcino-Sarcoma Rectal Abscess	
Due to (c) Metastasis & Uremia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W B Davis M.D.

M. D. or other

Address: Dundalk Md Date signed 3/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

19. Northrup
Harrison

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

CERTIFICATE OF DEATH

02607 Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 50 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: [redacted]

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 312 N. Hilton St., Balto., Md.

(If rural, give LOCATION)

2.(a) If veteran, oamo war: WW-I

3. (a) FULL NAME: JAMES W. HARTMAN (JAMES WARREN HARTMAN)

3. (b) Social Security Number: 213-05-0655

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Mildred A. Hartman

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): 12-22-93

8. AGE: Years	Months	Days	If less than one day
51	2	17	...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Ast. Marine Supt.

11. Industry or business: U: S. Steamship Co.

FATHER

12. Name: George Hartman

13. Birthplace: Maryland (Baltimore)

MOTHER

14. Maiden name: Mary E. Eiser

15. Birthplace: Maryland (Baltimore)

16. Informant: Clinical Records, Vets. Adm. Fac.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/13/45 (month) (day) (year)

Cemetery or crematory: New Cathedral Cem.

Location: Balto., Md.

18. Funeral director: Wm. J. Tickner & Son

Address: Baltimore, Maryland

19. 3/12 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9, 1945, at 10:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 18, 1945, to March 9, 1945 and that I last saw him alive on March 9, 1945

Immediate cause of death	DURATION
Tuberculosis, Chr. Pul. Par. Adv. Active	2 Yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: C. J. Kenney

C. J. KENNEY, M. D. CLINICAL DIRECTOR M.D. or other

Address: Fort Howard, Maryland Date signed: 3-10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

02608 P

CERTIFICATE OF DEATH

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 84 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 84 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County:

City or town: Alexandria
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1. Windsor Ave., Alexandria, Va.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I ✓

3.(a) FULL NAME: JOHN J. HAYES

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ///// Mrs. Catherine Hayes

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): 12-1-1890

8. AGE: Years	Months	Days	If less than one day
54	3	11	....hrs. ....min.

9. Birthplace: Elkins, W. Va.
(Town, county, and state)

10. Usual occupation: Dept. Guard

11. Industry or business:

FATHER — 12. Name: A.A. Hayes

13. Birthplace: ?

MOTHER — 14. Maiden name: Miraiah Grover

15. Birthplace: W. Va.

16. Informant: Clinical Records, Vets. Adm. Fac.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 17, 1945 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: Cunningham Undertaker

Address: Alexandria, Va.

19. 3/15 19 45 A.O. Kadrid Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14, 1945, at 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 20, 1944 to March 14, 1945 and that I last saw him alive on March 14, 1945

Immediate cause of death	DURATION
Carcinoma of Stomach	6 Mos.
	plus
Due to	
Due to	
Other conditions: Tuberculosis, pul. mod. advanced	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Kenney M.D. M. D. or other

J. J. KENNEY, M.D. CLINICAL DIRECTOR

Address: Ft. Howard, Md. Date signed: 3-15-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02609

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

Street No. 1702 Edmondson Avenue (If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Margaret Cecilia Hebner

3. (b) Social Security Number: --

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: Joseph Hebner

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): April 3, ~~1878~~ 1875

8. AGE: Years 69 Months 11 Days 6 If less than one day ... hrs. ... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: bookkeeper; housework

11. Industry or business: brother's home

FATHER

12. Name: Dennis Loden

13. Birthplace: Ireland

MOTHER

14. Maiden name: Mary Lanahan

15. Birthplace: Ireland

16. Informant: Hospital records

Address: Catonsville, Baltimore - 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-12-45 (month) (day) (year)

Cemetery or crematory: Baltimore

Location: Balt. Md

18. Funeral director: George A. Stanley

Address: Catonsville Md

19. 3/9 1945 (Date rec'd by registrar) H. C. Andrews, Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9, 1945, at 10:34 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death: Acute cardiac failure

Due to: fractured (neck surgical) femur right

Due to: Accidental fall. sudden death

Other conditions: Slipped, falling on floor. Inquiry (Include pregnancy within 3 months of death)

DURATION

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: Mch 2-45

Where did injury occur? Catonsville Balto Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) hospital

Means of injury: fractured femur Injured at work? no

23. SIGNATURE: Geo. W. Kieffer, Deputy Medical Examiner, Balto. Co. M.D. or other: Md

Address: 1010 Leeds av Date signed: 3-9-45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

02610

Reg. Dist. No. 8-3

1. PLACE OF DEATH:

County Balto.

City or town Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 11 months

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ruanna H. Hinkhaus

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Married

6.(b) Name of husband or wife William F. Hinkhaus

6.(c) If alive, give age 69. years

7. Birth date of deceased (mo., day, yr.) April 22, 1890

8. AGE: Years	Months	Days	If less than one day
54	10	11	...hrs. ...min.

9. Birthplace Waynesboro, Penn. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

FATHER 12. Name Noll

FATHER 13. Birthplace Dont Know

MOTHER 14. Maiden name Dont Know

MOTHER 15. Birthplace Dont Know

16. Informant William F. Hinkhaus.

Address Owings Mills

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 14, 1945 (month) (day) (year)

Cemetery or crematory Pleasant Hill

Location Owings Mills

18. Funeral director Unt. Berryman & Sons

Address Reisterstown, Md.

19. 3-13 1945 Grace Z. Arbaugh

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 11 1945, at 3 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-1 1945 to 3-11 1945

and that I last saw h... alive on 3-10 1945

Immediate cause of death	DURATION
Cardiac Decompensation	1 yr.
Hypertensive C. V. Disease	1 yr.
Due to Rheumatic C. V. Disease	1 yr.
Due to	
Other conditions Chr. Nephritis	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. D. Eagles, M. D.

M. D. or other

Address Reisterstown Date signed 3-13-'45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

02611

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Catonsville Convalescent Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1907 E. Lanvale St (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John K. Heizel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Anna C. Heizel

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 2, 1852

8. AGE: Years	Months	Days	If less than one day
93	1	6	hrs. min.

9. Birthplace: Swityland (Town, county, and state)

10. Usual occupation: Gardener

11. Industry or business:

FATHER — 12. Name: Dont know

13. Birthplace: Swityland

MOTHER — 14. Maiden name: Dont know

15. Birthplace: Swityland

16. Informant: Harold H. Heizel

Address: 2732 Fenwick Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 10 1945 (month) (day) (year)

Cemetery or crematory: Western

Location: Baltimore Md.

18. Funeral director: Ulrich Funeral Home

Address: 709 E. Orleans St

19. 3/9/45 (Date rec'd by registrar) 19.. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7 1945, at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1944, to March 7 1945

and that I last saw h.. alive on March 7 1945

Immediate cause of death	DURATION
Generalized arteriosclerosis	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Edward Lee Lucas M.D. M. D. or other

Address: Edmondson City Md Date signed: 3/9/45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Hicheu
Northern Pkwy. Belair

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02612

Reg. Dist. No. 38

P

1. PLACE OF DEATH:
County Baltimore Parkville
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
7807 Oakdale Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. Clayton Ave & Farmview Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Benedict J. Hochhaus

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Ruth Marie Hoshhaus
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9th, 1884

8. AGE: Years	Months	Days	If less than one day
61	--	21	hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation Foreman
11. Industry or business
FATHER 12. Name Charles E. Hochhaus
13. Birthplace Maryland
MOTHER 14. Maiden name Francis Strobel
15. Birthplace Maryland
16. Informant Mr. C. Irvin Hochhaus
Address 3036 Oak Forrest Drive
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/5/45 (month) (day) (year)
Cemetery or crematory Lorraine
Location Baltimore
18. Funeral director Leonard J. Ruck
Address 5305 Harford Road
19. 3/5 '45 (Date rec'd by registrar) D. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1945, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 1944 to May 2 1945
and that I last saw h.. alive on May 2 1945

	DURATION
Immediate cause of death	
Coronary heart disease	2 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. Lee Hicheu M.D. M. D. or other
Address 4116 Northern Parkway Date signed 2/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

02613

CERTIFICATE OF DEATH

Reg. Diat. No. 31

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills, P.O.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Owings Mills
(If ontside city or town limits, write RURAL and give nearest town)
Street No. Wemans Road, M. McDonough
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Frank Hohman

3.(b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mary Catherine Hohman
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 24 - 1859

8. AGE: Years	Months	Days	If less than one day
86		3	hrs. min.

9. Birthplace: Baltimore Co. Maryland
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Not known
13. Birthplace: Not known

MOTHER
14. Maiden name: Not known
15. Birthplace: Not known

16. Informant: Mrs. Joseph Schmidt
Address: Owings Mills, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 29-45 (month) (day) (year)
Cemetery or crematory: Holy Family
Location: Harrisville, Maryland

18. Funeral director: Frank H. Medford
Address: Pikesville, Maryland

19. 3/27/1945 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 19 45, at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 20 1945, to Mar. 27 1945, and that I last saw he alive on Mar. 26, 1945

Immediate cause of death	DURATION
Chronic Nephritis	7
Due to Arteriosclerosis	7
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other
Address: Randallstown Md. Date signed: 3/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7th a)

02614

CERTIFICATE OF DEATH

Reg. Diat. No. 31

1. PLACE OF DEATH

County Baltimore

City or town Randallstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Randallstown

(If ontside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Henry C Holbrook

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Elsie Spencer

(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) March 28 - 1880

8. AGE: Years 64 | Months 11 | Days 13 | If less than one day ... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation School bus driver

11. Industry or business

FATHER 12. Name Joseph Holbrook

13. Birthplace Md

MOTHER 14. Maiden name Clarissa A. Taylor

15. Birthplace Md

16. Informant Mrs Henry C Holbrook

Address Randallstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 12/45 (month) (day) (year)

Cemetery or crematory Mt Olive

Location Balto Co.

16. Funeral director Edw Clipton

Address Hampstead, Md

19. 3/10/45 (Date rec'd by registrar) H. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 10, 1945, at 5-40 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar 7, 1945, to Mar 10 1945

and that I last saw him alive on Mar 9, 1945

Immediate cause of death	DURATION
Coronary thrombosis	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. E. Martin M. D. or other

Address Randallstown Date signed 3/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

02615

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-D)

CERTIFICATE OF DEATH

Reg. Diat. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto.
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 407 Delaware Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: LENA C. HORST

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

B.(b) Name of husband or ~~wife~~: Charles C.
B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 22, 1883

8. AGE: Years	Months	Days	If less than one day
61	7	16	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: Thomas H. Hayden
13. Birthplace: Germany

MOTHER
14. Maiden name: Caroline Sittering
15. Birthplace: Unknown

16. Informant: Charles C. Horst
Address: 407 Delaware Avenue (Essex

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 12, 1945 (month) (day) (year)
Cemetery or crematory: Schwartz
Location: Baltimore, Maryland

18. Funeral director: William Cook, Inc.
Address: 1217 St. Paul Street

19. 3/11/45 (Date rec'd by registrar) John D Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8th 1945 at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1st 1944 to March 8 1945 and that I last saw h[illegible] alive on March 8 1945

Immediate cause of death	DURATION
Chronic Cardio-Renal Disease	5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no
Date of op.:
Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James F White M.D.
M. D. or other
Address: 7601 Eastern Ave, Baltimore 24 Md. Date signed: 3/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-C)

02616

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 103 days

Hospital, institution, or street address where death occurred:

Vet. Adm. Fac. Ft. Howard, Md.

How long in hospital or institution? 103 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County:

City or town: Leesburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I ✓

3.(a) FULL NAME: HOUGH, Irvin Clinton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Louise Hough

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): November 11, 1888

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
56	3	26		

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Charles Hough

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Bartola Harper

15. Birthplace: Virginia

16. Informant: Clinical Records

Address: Vets. Adm. Fac., Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/7/45 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Washington, D. C.

18. Funeral director: A. Lee Oder

Address: 4644 York Rd., Balto., Md.

19. 3/6/45 (Date rec'd by registrar) A. W. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4 1945, at 7.20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 21, 1944 to March 4, 1945 and that I last saw him alive on March 4, 1945

Immediate cause of death	DURATION
Metastatic Carcinoma of Frontal Bone	6 Mos.
Due to: Primary site of the carcinoma was not determined. C.W.G.R.	
Due to: There was nothing in the history to help determine the primary site of the carcinoma.	
Other conditions: Chronic Iritis & senile Cataracts	16mos

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Permission for post-mortem was not granted.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. J. Kenney M. D. or other

Address: Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17a)

CERTIFICATE OF DEATH

02617

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2906 Manhattan Ave., Balto., Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: SAW

3. (a) FULL NAME: WILLIAM G. HUDSON

3. (b) Social Security Number: 218-18-7143

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Helen Hudson

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): 11-17-79

8. AGE: Years	Months	Days	If less than one day
65	4	10	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: Henry Hudson
13. Birthplace: England

MOTHER
14. Maiden name: Catherine O'Rourke
15. Birthplace: Ireland

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 2, 1945 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: Wm. J. Tickner
Address: Baltimore, Md.

19. 3/29/45 (Date rec'd by registrar) 19.... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27, 1945, at 8:40P a.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22, 1945, to March 27, 1945 and that I last saw him alive on March 27, 1945

Immediate cause of death	DURATION
Generalized Peritonitis	8 Hrs.
Due to: Perforated Gastric Ulcer	8 Hrs.
Due to: Penetrating Gastric Ulcer	6 Weeks
Other conditions: Arteriosclerosis, generalized Anemia, secondary	

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....

Autopsy results: Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. J. KENNEY, M.D. CLINICAL DIRECTOR
M. D. or other

Address: Fort Howard, Maryland Date signed: 3-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02618

Reg. Dist. No. 32

1. PLACE OF DEATH:
County AUGSBURG HOME
City or town PIKESVILLE MD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County BALTO City
City or town PIKESVILLE MD
(If outside city or town limits, write RURAL and give nearest town)
Street No. CAMPFIELD ROAD
(If rural, give LOCATION)
2.(a) If veteran, name war 2318 Edmondson Ave.

3. (a) FULL NAME EMMA C KAMMER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEM	WHITE	WIDOW

6.(b) Name of husband or wife GEO. KAMMER
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) JULY 28-1860

8. AGE: Years	Months	Days	If less than one day hrs. min.
84	7	13	

9. Birthplace BALTO MD (Town, county, and state)
10. Usual occupation NONE
11. Industry or business
FATHER 12. Name HENRY FITZBERGER
13. Birthplace MD
MOTHER 14. Maiden name KATHERINE M SCHICKNER
15. Birthplace MD
16. Informant AUGSBURG. HOME RECORD
Address CAMPFIELD ROAD
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-16-45 (month) (day) (year)
Cemetery or crematory ~~Bur~~ Woodlawn Cem
Location Woodlawn Md.
18. Funeral director Mrs Chas. A. G. Rohde
Address 2327 Edmondson ave
19. 3/16 1945 A.W. Hedrick (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1945, at 12:55 P M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 3rd 1945, to March 13 1945
and that I last saw her alive on March - 10th 1945

Immediate cause of death	DURATION
1) - Fracture of Rt. Hip	-1 month
Due to	
Due to	
Other conditions - Broncho Pneumonia	-1 week

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No. Date of
Where did injury occur? - Balto. County Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) - Augsburg Home
Means of injury - Fall on floor Injured at work? - No.
23. SIGNATURE Earl L. Chambers M. D. or other
Address 4108 Liberty Hts. Date signed 3/14/45

Authorization to change residence - by phone from Mr. Katenkamp Augusburg Home. 4-6-45ams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

02619

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:
County: Baltimore
City or town: Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
7 Hillside Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7 Hillside Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ARTHUR ANDREW KANEEN

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillie May Kanneen
6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): May 31, 18 75

8. AGE: Years	Months	Days	If less than one day
69	9	19	..... hrs. ..... min.

9. Birthplace: Cockeysville, Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Retired

FATHER
12. Name: John Wm. Kaneen
13. Birthplace: Oxford, England

MOTHER
14. Maiden name: Susan Elizabeth Hyle
15. Birthplace: Maryland

16. Informant: Mrs. Lillie May Kaneen
Address: Cockeysville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 22, 1945 (month) (day) (year)
Cemetery or crematory: Prospect Hill Cemetery
Location: Towson, Maryland
18. Funeral director: John Burns' Sons
Address: Towson, Maryland
19. March 20 19 45 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19, 1945 19..., at 6 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1944, to March 19 1945 and that I last saw h.. alive on 3/19 1945

Immediate cause of death	DURATION
Chronic Nephritis (Uraemic coma)	5 yrs.
Due to	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wilmer C. Ensor M.D.
M. D. or other
Address: Cockeysville Md. Date signed 3/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M.)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I)

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

02620

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County.....

City or town.....Pikesville.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....?.....

Hospital, institution, or street address where death occurred:
3508n Old Court Road.

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....Maryland..... County.....

City or town.....Pikesville.....
(If outside city or town limits, write RURAL and give nearest town)

Street No.....3508 Old Court Road,.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME NATHAN H. KAUFMAN.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife.....Hilda H. Kaufman.....

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) May 13th. 1888.

8. AGE: Years	Months	Days	If less than one day
56	9	24	.....hrs. .....min.

9. Birthplace.....Baltimore, Md.....
(Town, county, and state)

10. Usual occupation.....Prop. Empire Laundry.....

11. Industry or business

FATHER 12. Name.....Frank Kaufman,.....

13. Birthplace.....Balto. Md.....

MOTHER 14. Maiden name.....Sadie Hess,.....

15. Birthplace.....Balto. Md.....

16. Informant.....Mrs. Hilda H. Kaufman,.....

Address 3508 Old Court Road.

17. Entombment Date thereof 3/13/45.
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Druid Ridge.....

Location.....Pikesville, Md.....

18. Funeral director.....David Sondheim & Son.....

Address 1902 Eutaw Place. Balto. Md.

19. 3-10-45 Dr. E.E. Nichols
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....March 9th.....19 45, at A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 6, 1925 19.....to Mar. 9, 19 45 and that I last saw him alive on Mar. 9, 19 45

Immediate cause of death	DURATION
Coronary occlusion	3 hrs.
Due to Arteria - sclerosis	3 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE.....E.E. Nichols.....
M. D. or other

Address 1041 St. Paul St. Date signed 3-10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 117-01

02621

CERTIFICATE OF DEATH

Reg. Dist. No. 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Middle River Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto.
City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2230 Old Eastern Ave
(If rural give LOCATION)
2.(a) If veteran, name war: World War # I

3.(a) FULL NAME: Frank Kerin, (FRANCIS W. KERIN)

3.(b) Social Security Number: 209-09-7650

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Ella Poole
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 2 1

8. AGE:

Years	Months	Days	If less than one day
52			hrs. ..... min.

9. Birthplace: Clearfield Co. Pa.
(Town, county, and state)
10. Usual occupation: Bartender
11. Industry or business: Pilot Cafe, Middle River

FATHER
12. Name: John F. Kerin
13. Birthplace: Ireland

MOTHER
14. Maiden name: Cath. Lynch
15. Birthplace: Ireland

16. Informant: Rev. Joseph Kerin
Address: Frenchtown, Pa.

17. Burial, cremation, or removal. Which?: Burial
Date thereof: 4-2-45 (month) (day) (year)
Cemetery or crematory:
Location: Clearfield Co, Pa.

18. Funeral director: John F. Connelly
Address: 418 Eastern Ave. Catonsville

19. 4-2-1945 (Date rec'd by registrar) John F. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-31-45 19..... at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Gastric Ulcer	
Due to	
Due to	
Other conditions: Hemorrhage - Gastric	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. P. Davis M.D.
Asst Dept. med. Examr Balto or other
Address: Cleveland Ave. Md. Date signed: 3-31-45

Kestner certificate

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4-C)

02622 P

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore Co

City or town: North Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto

City or town: North Point

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7609 Poplar ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Augusta Victoria Kestner Blasche

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles Kestner

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 3 - 1866

8. AGE: Years 78 | Months 9 | Days 16 | If less than one day: hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: At home

11. Industry or business

FATHER 12. Name: Adolph Johne

13. Birthplace: Germany

MOTHER 14. Maiden name: Dora Kenor

15. Birthplace: Germany

16. Informant: Mrs Howard McCaddin

Address: 3700 Ramona Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 23/45 (month) (day) (year)

Cemetery or crematory: St Paul's Ref Cem

Location: Cadult St Balto Md

18. Funeral director: Wilhelm Funeral Homes

Address: 2008 Orleans St

19. 3/21/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19 1945 at 5 15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1941 to Mar 19 1945

and that I last saw h.e.r. alive on Mar 17 1945

Immediate cause of death	DURATION
Carcinoma Cervix	4 mo.
Due to	
Due to	
Other conditions: Senility, Hypertensive Cardio-Vascular Disease	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H B Stevens M.D. M. D. or other

Address: 3408 Erdman Ave Date signed: 3/20/45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

02623

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:
County: Baltimore
City or town: Lutherville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Lutherville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: York Rd. & Seminary Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: J. Clinton Kidd

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife: Alice P.
6.(c) If alive, give age: deceased years
7. Birth date of deceased (mo., day, yr.): Feb. 19, 1855

8. AGE: Years	Months	Days	If less than one day
90	—	27	hrs. min.

9. Birthplace: Balto. Co. Md. (Town, county, and state)
10. Usual occupation: Merchant - Retired
11. Industry or business

FATHER
12. Name: Henry F. Kidd
13. Birthplace: Balto. Co. Md.

MOTHER
14. Maiden name: Margaret Heduck
15. Birthplace: Balto. Co. Md.

16. Informant: Wilson C. Kidd
Address: Lutherville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 20 1945 (month) (day) (year)
Cemetery or crematory: Poplar
Location: Cockeysville, Md.

18. Funeral director: Landon M. Brooks
Address: Sparks, Md.

19. March 19 45 (Date rec'd by registrar) Wilmer C. Enson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 1945, at 1.10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10- 1939, to May 18 1945
and that I last saw him alive on May 18 1945

Immediate cause of death	DURATION
Arteriosclerotic Heart disease	unk.
Due to Arteriosclerosis Renal	unk
Hypertension	unk
Due to Gall bladder disease	10-1939
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: none Date of —
Where did injury occur? none (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Bennett A. Olson M. D. or other
Address: Lutherville Date signed: 3/19/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

02624 D

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Mar Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, Institution, or street address where death occurred: at home
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Mar Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rolling Road
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: George Wroth Knapp Jr. **3.(b) Social Security Number:**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah L. Knapp 6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Feby - 28 - 1879

8. AGE: Years: 66 Months: 0 Days: 10 If less than one day: hrs. min.

9. Birthplace: Baltimore City (Town, county, and state)

10. Usual occupation: Accountant, Auditor

11. Industry or business: N.W. Mutual Life Co.

FATHER
12. Name: George W. Knapp
13. Birthplace: Maryland

MOTHER
14. Maiden name: Kate Boone
15. Birthplace: Maryland

16. Informant: Mrs Sarah L. Knapp (wife)
Address: Catonsville

17. Entombment (Burial, cremation, or removal. Which?) Date thereof: March 12 45 (month) (day) (year)
Cemetery or crematory: Druid Ridge
Location: Pikesville - Baltimore
18. Funeral director: Sherwood Mooney
Address: 108 W. Mt. Ave.

19. 3/10 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 10 19 45 at 12 15 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 14 19 43 to Mar 10 19 45 and that I last saw h— alive on Mar 9 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	1 hr
Due to: Hyper tension Cardio	
Vascular Disease	2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James H. Towers M. D. or other
Address: Catonsville Date signed: 3/10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

02625

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:

County: Baltimore

City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
7207 Bel Air Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7207 Bel Air Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Theresia Anna Kohlerman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	Wh	M

6.(b) Name of husband or wife: Henry C. Kohlerman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar 28, 1888

8. AGE: Years	Months	Days	If less than one day
57		1	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER
12. Name: Peter Unkelbach
13. Birthplace: Germany

MOTHER
14. Maiden name: Dora Ulrich
15. Birthplace: Germany

16. Informant: Mr. Henry C. Kohlerman

Address: 7207 BelAir Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 2, 45 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Belair Road

18. Funeral director: Grasske N. Sikitone

Address: 2918 E. Baltimore St.

19. 3/31/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 29, 1945, at 9.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 28, 1945, to Mar 29, 1945, and that I last saw her alive on Mar. 29, 1945.

	DURATION
Immediate cause of death: Diabetes mellitus	Known 3 mos.
Due to:	
Due to:	
Other conditions: Hypertension	12 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

22. SIGNATURE: A. L. Wilkinson
A. L. Wilkinson, M. D. or other

Address: 5713 Bel Air Rd. Date signed: 3-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73a)

CERTIFICATE OF DEATH

02626

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland 5 County: ~~Baltimore~~

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3113 Dillon Street
(If rural, give LOCATION)

2.(a) If veteran, name war: W.W. I

3.(a) FULL NAME: Jacob F. Kues

3.(b) Social Security Number: 212 20 1501

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Daisey B. Kues

6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): December 31, 1898

8. AGE: Years	Months	Days	If less than one day
46	2	10	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Supervisor for ash collection.

11. Industry or business

FATHER
12. Name: August Kues
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ella Wetzel
15. Birthplace: Pennsylvainia

16. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 14/45 (month) (day) (year)

Cemetery or crematory: Mt. Carmel Cem.

Location: Odonnell St.

18. Funeral director: Lilly & Zeiler, Inc.

Address: 1901 Eastern Ave. Balto. Md.

19. 3/12 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10 1945, at 8:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 1945, to March 10 1945, and that I last saw him alive on March 10 1945

	DURATION
Immediate cause of death:	
Anemia, pernicious with residual	
Due to: xxx paralysis of lower extremities	3 months
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. J. Kenney, M.D. or other

C. J. KENNEY, M.D. CLINICAL DIRECTOR

Address: Fort Howard, Maryland Date signed: 3-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information requested. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-2)

CERTIFICATE OF DEATH

02627 41

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1808 Kinship Road
(If rural, give LOCATION) --
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs Sophia A. Latham

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Chas. L. Latham
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 23, 1866

8. AGE: Years	Months	Days	If less than one day
78	11	4	hrs. min.

9. Birthplace: Germany
(Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: John N. Hubner
13. Birthplace: Germany

MOTHER
14. Maiden name: Helen B. Ziegler
15. Birthplace: Germany

16. Informant: Mrs. S. J. Miller
Address: 1808 Kinship Rd.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Mar. 30/45
(month) (day) (year)
Cemetery or crematory: Baltimore Cem.
Location: Balto. Md.
18. Funeral director: Philip Hennig Sons
Address: 2024 Orleans St.

19. 3/28/45 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 19 45, at 4 15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1, 1943 19 , to March 27 19 45 and that I last saw h[illegible] alive on March 26 19 45

Immediate cause of death	DURATION
Carcinoma of Lung	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. R. Evans M.D.
M. D. or other
Address: Liberty Parkway Date signed: 3-27-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

02628

CERTIFICATE OF DEATH

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Baltimore
City or town ~~Highlandtown~~ ~~Balto~~ Colgate
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto.
City or town ~~Highlandtown~~ Colgate
(If outside city or town limits, write RURAL and give nearest town)
Street No. Baltimore Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ella Nora Lay.
3. (b) Social Security Number

4. Sex F
5. Color or race W.
6.(a) Single, married, widowed, or divorced Widow.
6.(b) Name of husband or wife Louis
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) March 28 - 1879
8. AGE: Years 65 ~~66~~ Months 11 Days ~~16~~ 16 If less than one day ... hrs. ... min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual occupation at Home
11. Industry or business own
FATHER 12. Name Frederick Christian
13. Birthplace Germany
MOTHER 14. Maiden name Sophie Stall
15. Birthplace Baltimore
16. Informant Sophie Hesse (Daughter)
Address Baltimore Ave.
17. Burial Date thereof 3/19/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Oak Lawn
Location Eastern ave. Rd.
18. Funeral director John G Connelly
Address 418 Eastern ave. Balto 21.
19 3/19/ 19 45 John G Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 19 45, at 8 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death Coronary Occlusion	1 1/2 hrs.
Due to —	
Due to	
Other conditions Diabetes Mellitus	15 yrs

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE W. B. Davis M.D.
Asst Dep. Med. Exam. Balto Co.
Address Dundalk 22 Md. Date signed 3/15/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (153)

CERTIFICATE OF DEATH

02629

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1-1/2 yrs.
Hospital, institution, or street address where death occurred:
7008 Plymouth Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7008 Plymouth Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: EDNA WALKER LEFTWICH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Douglass Lee Leftwich
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 4, 1885

8. AGE: Years	Months	Days	If less than one day
59	8	11	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: B. F. Walker
13. Birthplace: Kent Island, Md.

MOTHER
14. Maiden name: Mary F. Harmer
15. Birthplace: Salem, N. J.

16. Informant: Naomi W. Horn
Address: 408 Wimslow Rd., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 17, 1945 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Baltimore, Md.

18. Funeral director: Wm. J. Tickner & Sons,
Address: North & Penna. Aves., Balto., Md.

19. 3/16/ 1945 (Date rec'd by registrar) E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15th, 1945, at 11-PM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1943, to March 15th 1945 and that I last saw her alive on March 15th, 1945

Immediate cause of death	DURATION
Chronic Myocarditis	?
Chronic Elephantiasis	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: E E Nichols M.D.
M. D. or other
Address: Pikesville-8, Md. Date signed Mch 16 '45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02630 35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Balto
City or town Glencoe Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Glencoe Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Old Field School
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Viola Maud Lemmon

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widow

6 (b) Name of husband or wife John H.
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22. 1871

8. AGE: Years	Months	Days	If less than one day
73	4	27.	hrs. min.

9. Birthplace York, Pa.
(Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name Daniel Hussa
13. Birthplace Penn.
MOTHER 14. Maiden name Barbara Ann Crawford
15. Birthplace Penn.
16. Informant Mr. Irving C. Lemmon
Address 628 S. Dunstan Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 22, 45 (month) (day) (year)
Cemetery or crematory Loudes
Location Westminster Md
18. Funeral director J. J. Kleman & Son
Address 32 E. Broadway.
19. 3/21 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 19 19 45, at 7 50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1 19 45, to Mar. 19 19 45, and that I last saw h-- alive on Mar. 19 19 45.

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions Hypertension	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE G. M. Frame M. D. or other
Address Parkton, Md. Date signed 3/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (28)

CERTIFICATE OF DEATH

02631

Reg. Dist. No. 9-38

1. PLACE OF DEATH:
County Baltimore
City or town Towson, 4, Maryland.
(If outside city or towo limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Eudowood Sanatorium, Towson, 4, Md.
How long in hospital or institution? 4 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore City.
City or town Baltimore
(If outside city or towo limits, write RURAL and give nearest town)
Street No. 1642 Ruxton ave
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Frances Annette Hipnicka.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) June 7, 1943
8. AGE: Years 1 | Months 10.9 | Days 15 | If less than one day ..... hrs. ..... min.
9. Birthplace Maryland. (Town, county, and state)
10. Usual occupation —
11. Industry or business —
FATHER 12. Name Bernard Hipnicka
13. Birthplace Maryland.
MOTHER 14. Maiden name Judith Ellison
15. Birthplace Maryland
16. Informant Family History--Hospital Records
Address Eudowood Sanatorium, Towson, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-22-45 (mooth) (day) (year)
Cemetery or crematory Star Crow
Location Bowleys Lane
18. Funeral director Jack Lewis Inc
Address 1409 E Balto St
19. 3/22/45 (Date rec'd by registrar) Howard Saulsbury Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1945, at 4:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Birth 19.. to March 21 1945
and that I last saw her alive on March 21, 1945

Immediate cause of death	DURATION
Cystic Fibrosis of Pancreas	20 mos.
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. H. Finkelstein M. D. or other
Address Towson, 4, Md. Date signed 3/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02632

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months, 1 day

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 9 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: ~~Catonsville~~ 28

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1415 Homestead Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Louisa Loeser

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Eric Loeser

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 9, 1894

8. AGE: Years	Months	Days	If less than one day
51	2	5	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: Ferdinand Valkert

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Johanna Lehneir

MOTHER — 15. Birthplace: Germany

16. Informant: Hospital records

Address: Catonsville, Balto.-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-18-45 (month) (day) (year)

Cemetery or crematory: London Park

Location: Baltimore Md

18. Funeral director: Geo. A. Fahey

Address: Catonsville

19. 3/15 1945 (Date rec'd by registrar) H. C. Andreae Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14 1945 at 11:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13 1944, to March 14 1945 and that I last saw her alive on March 14 1945

Immediate cause of death	DURATION
Terminal broncho pneumonia	11 hrs.
Due to: Acute myocardial failure	4 hrs.
Due to: Chronic hypertensive cardio-vascular disease	Indef.
Other conditions: Obesity	"

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.

Robert E. Gardner, M.D. M. D. or other

Address: Catonsville, Balto.-28, Md. Date signed: 3/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (109)

CERTIFICATE OF DEATH

02633

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, Institution, or street address where death occurred: 35 Alleghaney Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 35 Alleghaney Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: CLAUDIUS R. LUMPKIN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of ~~husband or~~ wife: Laura M. Lumpkin

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): September 12, 1861

8. AGE: Years	Months	Days	If less than one day
83	6	14	— hrs. — min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Transfer Business

11. Industry or business: Retired

FATHER 12. Name: Robert Lumpkin

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden name: Amanda Lumpkin (?)

MOTHER 15. Birthplace: North Carolina

16. Informant: Mrs. Joseph S. Parker

Address: 35 Alleghaney Ave, Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 28, 1945 (month) (day) (year)

Cemetery or crematory: Prospect Hill Cemetery

Location: Towson, Maryland

18. Funeral director: John Burns' Sons

Address: Towson, Maryland

19. 3/29/45 (Date rec'd by registrar) C. W. Hendrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26, 1945 at 305 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 12, 1945 to Mar 26 1945

and that I last saw h... alive on March 25 1945

Immediate cause of death	DURATION
Pneumonia (Years)	3 wks.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D.

M. D. or other

Address: Towson, Md. Date signed: 3/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec. d. U.S.
3/28/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

02634 P

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3021 Woodside Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary B. Mallery

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Charles G.
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 20, 1861

8. AGE: Years	Months	Days	If less than one day
83	6	15	____ hrs. ____ min.

9. Birthplace: N. H. (Town, county, and state)
10. Usual occupation: house wife
11. Industry or business
FATHER — 12. Name: Charles Burr; 13. Birthplace: N.Y.
MOTHER — 14. Maiden name: Mary Blackwell; 15. Birthplace: N.Y.
16. Informant: Mr. B. Mallery
Address: 3021 Woodside Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/9/45 (month) (day) (year)
Cemetery or crematory: Whitemarsh Mem. Park
Location: Roxboro Phila. Pa.
18. Funeral director: Clarence F. Hoffmann
Address: 1639 N. Broadway.
19. 3/8 45 (Date rec'd by registrar) a. W. Hedgins per M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7 1945 at 2 30 am M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 14 1945 to March 7 1945
and that I last saw h[illegible] alive on March 6 1945

Immediate cause of death	DURATION
Renal Regurgitation Decompensation	21 d.
Bronchial Pneumonia	21 d.
Due to: Arteriosclerosis	21 d
Hypertension	21 d.
Due to: Chronic Parenchymatous Nephritis	21 d
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ____ Injured at work?

23. SIGNATURE: Thos. F. A. Stevens M.D.
M. D. or other
Address: 2878 Hartford Rd Date signed: 3-8-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Rec'd. U.S.
3/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

02635 31

Reg. Diat. No.

1. PLACE OF DEATH:
County: Allegheny Home
City or town: Cumberland Town
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto. City
City or town: Pikesville (If outside city or town limits, write RURAL and give nearest town)
Street No.: Campfield RR (If rural, give LOCATION)
2.(a) If veteran, name war: 4374 Park Heights Ave.

3.(a) FULL NAME Mrs. Eliza C. March

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	

6.(b) Name of husband or wife: Allen March
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Sept 4 1856

8. AGE: Years: 88 | Months: 7 | Days: 5 | If less than one day: hrs. min.

9. Birthplace: Balto.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER — 12. Name: William Reed
13. Birthplace: Unknown

MOTHER — 14. Maiden name: Eliza ?
15. Birthplace: Unknown

16. Informant: Mrs. Katenkamp
Address: Campfield RR

17. Burial (Burial, cremation, or removal) (Which?) Date thereof: March 11 (month) (day) (year)
Cemetery or crematory: Garden of
Location: Federal Rd.

18. Funeral director: L. HECHMANN & SON
Address: 32 S. Broadway

19. 3/12 19 45 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9th 19 45, at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18th 19 44, to March 9th 19 45
and that I last saw h.s.s. alive on March 8th 19 45

Immediate cause of death	DURATION
1 - Cerebral Arterio Sclerotic Heart Disease	5 yrs.
Due to	
Due to	
Other conditions - Bronchopneumonia Arterio Sclerosis.	

(Include pregnancy within 3 months of death)

Major findings of operation: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Earl L. Chambers, M. D. or other
Address: 4108 Liberty Ht. Date signed: 3/10/45

Such to change residence - by phone from Mr. Katenkamp, Augsburg home. 4-3-45. AMS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

02636

CERTIFICATE OF DEATH

Reg. Dist. No. 2 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since August 20, 1944
Hospital, institution, or street address where death occurred: Eudowood Sanatorium, Towson, Md.
How long in hospital or institution? Since August 20, 1944

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Ebbey - Balto 21 Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8240 Eastern Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Dorothy Elizabeth Marquardt

3.(b) Social Security Number: 211-07-3424

4. Sex: Female
5. Color or race: White
(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Bernard Marquardt
6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): March 2, 1919

8. AGE: Years: 26 Months: — Days: 21 If less than one day: — hrs. — min.

9. Birthplace: Girardville Pa
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: Carl Stridly
13. Birthplace: Raven Run Pa

MOTHER
14. Maiden name: Florence Whitaker
15. Birthplace: Raven Run Pa

16. Informant: Personal History, Hospital Records
Address: Eudowood Sanatorium, Towson, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Mar. 27 1945 (month) (day) (year)
Cemetery or crematory: J. M. Clarke, Funeral Home
Location: Girardsville, Penna.

18. Funeral director: John Burns' Sons
Address: Towson, Maryland

19. 3/24 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24 1945, at 11 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 20 1944, to March 24 1945
and that I last saw h.r. alive on March 24 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Since July 1944
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William A Bridges M. D.
Address: Towson 4, Maryland Date signed: 3-24-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

02637 P

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Weeks.

Hospital, institution, or street address where death occurred: Wood's Nursing Home, 5313 Edmondson Ave.

How long in hospital or institution? 2 Weeks.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 612 Glenolden Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: HENRIETTA MARX.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Marcus Marx

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 30th. 1865.

8. AGE: Years	Months	Days	If less than one day
79	2	24	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Levi Wheatfield.

13. Birthplace: Germany.

MOTHER — 14. Maiden name: Bertha ?

15. Birthplace: Germany.

16. Informant: Miss. Bertha Marx.

Address: 612 Glenolden Ave. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 26, 1945 (month) (day) (year)

Cemetery or crematory: Hebrew Friendship

Location: Baltimore, Md.

18. Funeral director: Harris Sonneborn & Son

Address: 1902 Eutaw Place. Balto. Md.

19. 3/26 19 45 (Date rec'd by registrar) C. W. Hedrich per HD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24th. 19 45, at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22 19 45, to March 30 19 45 and that I last saw h[illegible] alive on March 23 19 45

Immediate cause of death	DURATION
Hypostatic Pneumonia	2 days
Terminal	
Due to: Cardio Vascular	
Disease & Decompensation	5 Years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Eliot W. Johnson MD

M. D. or other

Address: 3432 Frederick Ave. Date signed: 3/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Re d. U. S.
3/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-7)

02638

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Lutherville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Lutherville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Lincoln Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Masse

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: Forrest
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 1, 1886

8. AGE: Years	Months	Days	If less than one day
59			..... hrs. ..... min.

9. Birthplace: Loudown Co. Va
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Benjamin Chatman
13. Birthplace: Va
MOTHER 14. Maiden name: Unknown
15. Birthplace:
16. Informant: Mrs. Lizzie Minor
Address: Lincoln Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 13, 1945 (month) (day) (year)
Cemetery or crematory: Pleasant Rest
Location: Towson, Md.
18. Funeral director: Mrs. Lenny M. Holland
Address: 1681 Druid Hill Ave.
19. Mar. 11, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9, 1945 at 8:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9, 1945, to March 9, 1945
and that I last saw her alive on March 9, 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	four hrs.
Due to:	
Due to: Hypertension	10 yrs.
Hg. Philes –	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: none Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Bennett A. Stearn M. D. or other
Address: Lutherville, Md. Date signed 3-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

02639

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Edgewood
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Box #2, Edgewood, Maryland
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I ✓

3. (a) FULL NAME: EDWARD MC CUSKER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emma Mc Cuskor

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): 7-11-91

8. AGE: Years	Months	Days	If less than one day
53	7	23	...hrs. ...min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER — 12. Name: Patrick McCusker

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Jennie Payne

MOTHER — 15. Birthplace: Ohio

16. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-12-45 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: James L. McCauley
Address: 128 E. Fort Ave., Balto., Md.

19. 3/9 (Date rec'd by registrar) 19 45 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8, 19 45, at 12:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6, 19 45, to March 8, 19 45 and that I last saw him alive on March 8, 19 45

Immediate cause of death	DURATION
Disease of the Heart.	5 Yrs.
Due to: Hypertension, coronary, arteriosclerosis	
Due to: myocardial insufficiency.	
Due to:	
Other conditions: Nephrosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. J. Kenney
C. J. KENNEY, M.D. CLINICAL DIRECTOR
Address: Fort Howard, Maryland Date signed: 3-9-45

M. D. or other

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02640

CERTIFICATE OF DEATH

Reg. Diat. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac., Fort Howard, Maryland

How long in hospital or institution? 30 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 820 E. Pratt St., Balto., Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW

3. (a) FULL NAME: THOMAS A MC GEE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ////// Single

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 12-31-91

8. AGE: Years	Months	Days	If less than one day
53	2	23	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and atate)

10. Usual occupation: Printer

11. Industry or business

FATHER — 12. Name: Thomas McGee

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Annie Sauer

15. Birthplace: Baltimore, Maryland

16. Informant: Vets. Adm. Fac. Ft. Howard, Md.

Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-30-45 (month) (day) (year)

Cemetery or crematory: Baltemoie Baltimore

Location: Baltimore

16. Funeral director: Leonard J. Ruck

Address: 5305 Harford Ave., Balto., Md.

19. 3-30 1945 (Date rec'd by registrar) G. M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26, 1945, at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 24, 1945, to March 26, 1945 and that I last saw him alive on March 26, 1945

Immediate cause of death	DURATION
Tuberculosis, chr. pul. far. adv.	2 Mos.
	plus
Due to	
Due to	
Other conditions: Arteriosclerosis, generalized	
Varicose veins left leg.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work? N/A

23. SIGNATURE: G. M. Kenney

G. M. KENNEY, M.D. CLINICAL DIRECTOR
M. D. or other

Address: Fort Howard, Maryland Date signed: 3-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02641

Reg. Diat. No. 4 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto
City or town: Randallstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8711 Wendell Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Curtin John McGowan

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna M. Mc. Gowan
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 6 - 1892

8. AGE:

Years	Months	Days	If less than one day
52	6	25	..... hrs. ..... min.

9. Birthplace: Sparrows Pt. Md. (Town, county, and state)
10. Usual occupation: Boiler Maker
11. Industry or business: Bethlehem Ship Bldg

FATHER
12. Name: John Mc. Gowan
13. Birthplace: Pa.

MOTHER
14. Maiden name: Mary Padden
15. Birthplace: Pa.

16. Informant: Mrs. Anna M. Mc. Gowan
Address: 8711 Wendell Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-5-45 (month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: Baltimore

18. Funeral director: Leonard J. Ruck
Address: 5305 Harford Rd.

19. 3/1 /45 Alb. Helsel DR. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1st 1945 at 6-20 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ ..... 19.. to ..... 19.. ~~and that I last saw h.~~ ..... alive on ..... 19..

Immediate cause of death	DURATION
Coronary thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: M. D. Mc Lady M. D. or other
Address: Pikesville Md. Date signed March 1 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

02642 P

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

County: Baltimore

City or town: Dundalk (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County:

City or town: Dundalk (If outside city or town limits, write RURAL and give nearest town)

Street No. 56 York Way (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: James McDowan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widower

6.(b) Name of husband or wife: Late Viola

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 27th 1866

8. AGE: Years	Months	Days	If less than one day
78	11	16	hrs. min.

9. Birthplace: Harrisburg, Pa. (Town, county, and state)

10. Usual occupation: Stationary Eng. (Retired)

11. Industry or business: Sparrows Point

FATHER 12. Name: James McDowan

13. Birthplace: Pa.

MOTHER 14. Maiden name: Anne Krout

15. Birthplace: Pa.

16. Informant: Mrs. Harold Wilson

Address: 56 York Way. Dundalk.

17. Burial: (Burial, cremation, or removal. Which?) Date thereof 3/16/45 (month) (day) (year)

Cemetery or crematory: London Park

Location: Frederick Ave

18. Funeral director: John J. Kenny Inc. - L.D. Sb.

Address: 715 Light St.

19. 3/16 1945 A. W. Hedrick Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13 1945, at 9.45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1, 1945, to March 13 1945 and that I last saw h.. alive on March 13 1945

Immediate cause of death	DURATION
Coronary Thrombosis	1 wk
Due to: Hypertensive - Arteriosclerotic Heart Disease	1 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. R. Evans M. D. or other

Address: Liberty Cashway Date signed 3-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Doc. d. U.S.
3/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

02643

Reg. Dist. No. 644

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 21 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 607 N. Calhoun Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW ✓

3. (a) FULL NAME: WALTER MC NEAL

3. (b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	Colored	Married--Sep.

6.(b) Name of husband or wife: Frances Mc Neal

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 7-9-99

8. AGE: Years	Months	Days	If less than one day
45	7	21	..... hrs. ..... min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Operator

11. Industry or business:

FATHER — 12. Name: Alexander McNeal
13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Maggie Williams
15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-6-45 (month) (day) (year)

Cemetery or crematory:

Location: Petersburg, Virginia

18. Funeral director: Mrs. Frances A. Hemsley

Address: 578 W. Biddle St.

19. 3-5-45 (Date rec'd by registrar) John B. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2, 1945, at 11:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 9, 1945, to March 2, 1945; and that I last saw him alive on March 2, 1945

Immediate cause of death	DURATION
Bronchogenic Carcinoma rt. lung	6 Mos.
	plus
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work? N/A

23. SIGNATURE: C.J. KINNEY, M.D. CLINICAL DIRECTOR
M. D. or other

Address: Ft. Howard, Maryland Date signed: 3-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

02644 7

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore

City or town Sparrows Point
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 514 D St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Baltimore

City or town Sparrows Point Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 514 D Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Aaron M. Miller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Emma J. Miller

6(c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) March 30, 1880

8. AGE: Years	Months	Days	If less than one day
65	0	1	hrs. min.

9. Birthplace Millersburg, Pa.
(Town, county, and state)

10. Usual occupation Dock Foreman

11. Industry or business Bethlehem Steel Corp

FATHER 12. Name Samuel M. Miller

13. Birthplace Millersburg Pa.

MOTHER 14. Maiden name Elizabeth J. Unknown

15. Birthplace unknown

16. Informant Mrs Blanch Casey

Address 1636 Abbottston St.

17. Burial Date thereof 4/4/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Meadowridge Cemetery

Location Washington Blvd.

18. Funeral director John F. Kilemy Inc, C. L. Hess

Address 715 Light St.

19. 4/4/45 A. W. Hedrick per H.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 19 45, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23 19 45, to March 31 19 45, and that I last saw h alive on March 29 19 45.

Immediate cause of death	DURATION
Acute Coronary Occlusion	8 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. E. Windsor, M. D.
M. D. or other

Address 520 D St. Sparrows Pt. Date signed 5-31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd. U.S.
4/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

02645

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VSA15

1. PLACE OF DEATH

County: Balto.

City or town: Pikesville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Augsburg Home Campfield Rd

Stay in hospital or inst. (yrs., or mos., or days): 6 yrs.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)

State: Md. County: Baltimore

City or town: Pikesville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Campfield Rd (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: — 406 N. Glover St. ✓

3. (a) FULL NAME: Margaut Miller

3. (b) Social Security Number:

4. Sex: F. | 5. Color or race: W. | 6.(a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Fredpick Miller

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): apr. 5, 1862

8. AGE: Years: 82 | Months: 10 | Days: 28 | If less than one day: hrs. min.

9. Birthplace: Balto. City (Town, county, and state)

10. Usual occupation:

11. Industry or business: —

FATHER 12. Name: Louis Rossman

13. Birthplace: ?

MOTHER 14. Maiden name: Unknown

15. Birthplace: ?

16. Informant: Mr. Theo. Katenkamp Address: Campfield Rd Pikesville

17. Burial: Burial (Burial, cremation, or removal. Which?) Date thereof: Mch. 6. 45 (month) (day) (year)

Cemetery or crematory: Emmanuel

Location: Glyndon Jane

18. Funeral director: J. Heimann & Son Address: 32 S. Broadway

19. 3/5 (Date rec'd by registrar) 19 45 Registrar: A. W. Hedrick

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 1945, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 20th 1945, to March 3 1945, and that I last saw h e alive on March 1st. 1945

	DURATION
Immediate cause of death: 1) Cerebral Hemorrhage	3 wks.
Due to: Hypertension Heart disease	5 yrs. ?
Due to:	
Other conditions: None Generalized Arterio-Sclerosis. (Include pregnancy within 3 months of death)	

Major findings:

20 operations: None

20 autopsy: No

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Earl L. Chambers M. D. or other

Address: 4108 Liberty Hts. Date signed: 3/3/45

Auth. to change residence - by phone from Mr. Katenkamp, Augsburg Home 4-6-45. ans

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

02646

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 7 mos., 6 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 7 mos., 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore Co.

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8 Hillside Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Charles F. Miller - Alias Kasis Miliauskas

3.(b) Social Security Number: # Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 26, 1897

8. AGE: Years	Months	Days	If less than one day
47	5	15	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Presser

11. Industry or business

FATHER — 12. Name: Charles Miller

FATHER — 13. Birthplace: Lithuania

MOTHER — 14. Maiden name: Agnes Krakouskas

MOTHER — 15. Birthplace: Lithuania

16. Informant: Charles F. Miller

Address: 8 Hillside Rd., Catonsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 16, 1945 (month) (day) (year)

Cemetery or crematory: Holy Redeemer Cemetery

Location: 4430 Belair Rd., Balto., Md.

18. Funeral director: Wm. J. Tickner & Sons

Address: Pa. and North Ave., Balto., Md.

19. March 13, 1945 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13, 1945 19 45 at 5:25A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 7, 1944, to March 13, 1945 and that I last saw him alive on March 13, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yrs. 6 mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D.
M. D. or other

Address: Mount Wilson, Md. Date signed: 3/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

02647 P

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Facility, Ft. Howard, Maryland

How long in hospital or institution? 25 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ~~Baltimore~~

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. ~~1512~~ Carey Street
1313 (If rural, give LOCATION) ✓

2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN H. MITCHELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: ////////

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 7-18-87

8. AGE: Years	Months	Days	If less than one day
57	7	14	..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER
12. Name: Reuben Mitchell
13. Birthplace: Virginia

MOTHER
14. Maiden name: Louhanna Rock
15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-8-45 (month) (day) (year)

Cemetery or crematory: Balto National

Location: Frederick Rd

18. Funeral director: R Lee Adler

Address: 4644 York Rd.

19. 3/7 19 45 C.W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5, 1945, at 12:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 8, 1945, to March 5, 1945 and that I last saw him alive on March 5, 1945

	DURATION
Immediate cause of death: Tuberculosis, chr. pul. far adv.	3 Yrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? No

23. SIGNATURE: C.J. Kenney
C.J. KENNEY, M.D. CLINICAL DIRECTOR
M. D. or other

Address: Ft. Howard, Maryland Date signed: 3-5-45

Rec'd. U.S.
3/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

02648

CERTIFICATE OF DEATH

Reg. Dist. No. 33 ~

1. PLACE OF DEATH:
County: Baltimore.
City or town: Rural near White Hall Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore.
City or town: Rural near White Hall.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: East of White Hall.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Lillian Jane Mitchell.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife: Richard Parker Mitchell.
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): June 5, 1873.

8. AGE: Years	Months	Days	If less than one day
71	9	2	hrs. min.

9. Birthplace: Haure de Grace Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home.
12. Name of father: Alfred M. Touchton
13. Birthplace of father: Harford Co. Md.
14. Maiden name of mother: Annie E. [illegible]
15. Birthplace of mother: Harford Co. Md.
16. Informant: R. Parker Mitchell.
Address: White Hall, Md. R.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 9 1945 (month) (day) (year)
Cemetery or crematory: Bethel Cemetery.
Location: Madonna, Baltimore Co. Md.
18. Funeral director: Jacob Hartenstein
Address: New Freedom Pa.
19. Mar 8 1945 (Date rec'd by registrar) Registrar: Charles L. Fuller

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7, 1945 19 at 12:40 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 42, to Mar. 7 19 45
and that I last saw h[illegible] alive on Mar. 6 19 45

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to	
Other conditions: Chronic myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. M. France M. D. or other
Address: Parkton, Md. Date signed: 3/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr Taylor 2810 Taylor Av Blvd 137

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

02649

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Balto

~~City or~~ town Parkville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs.

Hospital, institution, or street address where death occurred:

3014 Taylor Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto.

~~City or~~ town Parkville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3014 Taylor Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Maggie E. Mockard

3. (b) Social Security Number

4. Sex	5. Color or race	6. ~~(a) Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6.(b) Name of husband or wife Elemer E. Mockard

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 13th 1872

8. AGE: Years	Months	Days	If less than one day
73	2	18	..... hrs. ..... min.

9. Birthplace Pa (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER 12. Name Francis Wilson

13. Birthplace Ireland

MOTHER 14. Maiden name Mary (Unknown)

15. Birthplace Pa.

16. Informant Mrs Viola Dewey

Address 3014 Taylor Ave. Parkville

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof April 3rd 1945 (month) (day) (year)

Cemetery ~~or crematory~~ Parkwood

Location Parkville Md

18. Funeral director William Cook Inc

Address 1217 St. Paul St. Balto. Md.

19. 3-31 1945 A.M. Bacon Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 31st 1945, at 9:55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935, to Mar. 31 1945

and that I last saw h.. alive on Mar. 31 1945

Immediate cause of death	DURATION
Angina Pectoris	6 yrs.
Due to Hypertension	10 yrs.
Chron. myocarditis	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE A. M. Bacon, M. D. (M. D. or other)

Address 2810 Taylor Ave. Date signed 3/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of ~~death~~ clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

02650

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Opitz Home Edmondson Ave. and Nunnery Land

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Solley, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: ELOF T. NELSON

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Oliva

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 17, 1862

8. AGE: Years	Months	Days	If less than one day
82	3	22	hrs. min.

9. Birthplace: Sweden
(Town, county, and state)

10. Usual occupation: Engineer, Retured

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Sweden

MOTHER
14. Maiden name: Unknown
15. Birthplace: Sweden

16. Informant: Esther Tobiason

Address: 108 8th Ave., Brooklyn Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/12/45 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Brooklyn, A.A.Co., Md.

19. Funeral director: William Lee Inc

Address: 1219 E Pratt St

19. 3/9 1945 (Date rec'd by registrar) H. C. Andrews Deputy Registrar (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9th 1945, at 5-20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2 1945 to Mar 9 1945 and that I last saw him alive on Mar 8 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	4 days
Due to: Generalized Arterio Sclerosis	2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Catonsville Md. Date signed 3/9

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85a

CERTIFICATE OF DEATH

02651

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Balto.

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 yrs.

Hospital, institution, or street address where death occurred: N. Towson Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No. N. Towson

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Henry Nolan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	C	Widowed

6.(b) Name of husband or wife Annie Nolan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 17th 1879

8. AGE: Years	Months	Days	If less than one day
65			..... hrs. ..... min.

8. Birthplace Cockeysville Md. Balto. Co. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Thomas Nolan

13. Birthplace Md

MOTHER 14. Maiden name Lucy Fisher

15. Birthplace Md

18. Informant Mamie Nolan

Address N. Towson Md. Balto Co.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3rd 25th 1945 (month) (day) (year)

Cemetery or crematory Pleasant Rest Cem.

Location Towson Balto Co. Md

18. Funeral director Bryant Mamie C. Knight

Address 721 Aisquith St Balto 2 Md

19. 3/26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1945 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 1st 1945 to March 20 1945

and that I last saw him alive on March 19 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage, Rt. Hemiplegia	5 days
Due to Hypertension	unk.
Due to Arteriosclerosis	unk.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date of

Where did injury occur? none (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bennett A. Stone M. D. or other

Address Lutherville Date signed 3/21/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

02652

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Balto
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~Hospital, institution, or~~ street address where death occurred: 5 N. Brechwood Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5 N. Brechwood Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Jesse B. Overman

3.(b) Social Security Number:

4. Sex	5. Color or race	6. ~~(a) Single, married, widowed, or divorced~~
Male	White	Widowed

6.(b) Name of ~~husband or~~ wife: Ida Overman
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar 20th 1874

8. AGE: Years	Months	Days	If less than one day
70	11	29	hrs. min.

9. Birthplace: Portsmouth Va. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Bendix Corp.
FATHER 12. Name: Ralph Overman
13. Birthplace: Va.
MOTHER 14. Maiden name: Unknown
15. Birthplace: "
16. Informant: Everett F. Overman
Address: 5 N. Brechwood Ave. Catonsville
17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 3/21/45 (month) (day) (year)
Cemetery or ~~crematory~~: London Park
Location: Balto. Md.
16. Funeral director: William Cook Inc
Address: 1217 St. Paul St
19. 3/21 1945 (Date rec'd by registrar) G. W. Gehrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 19th 1945, at 4:20 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-18 1939 to 3-19 1945 and that I last saw h... alive on 3-18 1945

	DURATION
Immediate cause of death: Coronary Embolism	1/2 hrs.
Due to: Auricular Fibrillation	2 mos.
Due to: Myocarditis	2 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 802 Ingleside Ave Catonsville 28 Md Date signed: 3-19-45

MARGIN RESERVED FOR BINDING

Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK

VS A15

Rec'd U.S.
3/21/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46 F)

CERTIFICATE OF DEATH

02653 34

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Beckleysville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred: —
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Beckleysville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: John Wlesley Patterson.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Catherine Patterson 6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Oct 21, 1859

8. AGE:

Years	Months	Days	If less than one day
85	4	11	hrs. min.

9. Birthplace: Beckleysville Balto Co. Maryland (Town, county, and state)

10. Usual occupation: Retired Farmer.

11. Industry or business: agriculture

FATHER
12. Name: John Patterson.
13. Birthplace: Maryland

MOTHER
14. Maiden name: Susanne Baublitz
15. Birthplace: Maryland.

16. Informant: Elizabeth Catherine Patterson
Address: Hampstead, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 6-45 (month) (day) (year)
Cemetery or crematory: Beckleysville
Location: Balto Co Md

18. Funeral director: Edw A Tipton
Address: Hampstead Md

19. Mch 4 1945 (Date rec'd by registrar) C.E. Fouke M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2. 1945, at 10 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 18 1945, to March 2 1945 and that I last saw h.i.m. alive on March 2 1945

Immediate cause of death	DURATION
Primary Carcinoma Liver	?
Due to	
Due to	
Other conditions Cirrhosis-Infiltrative-Cardiac Vascular Disease (Include pregnancy within 3 months of death)	?

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: — Injured at work? —

23. SIGNATURE: Jack E. Buck M.D. M. D. or other
Address: Hampstead Md Date signed 3/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02654

Reg. Dist. No. 42

1. PLACE OF DEATH:
County: Baltimore
City or town: Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5512 Link Ave,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles Polster

3.(b) Social Security Number: 705-09-6442

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: **** Anna M. Polster.
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): April 16. 1876

8. AGE: Years	Months	Days	If less than one day
68	II	23	hrs. min.

9. Birthplace: Baltimore. Maryland.
(Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Baltimore & Ohio R. R.

FATHER
12. Name: Conrad Polster
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Elizabeth Gumpman
15. Birthplace: Maryland

16. Informant: Mrs Anna M. Polster
Address: 5512 Link Ave, Halethorpe.Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/27/1945 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Old Frederick Rd, Baltimore
18. Funeral director: Howard A. Dill
Address: 19 W. Pennsylvania Ave, Towson.

19. 3/26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24. 1945, at I-30Am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 1945, to March 24 1945
and that I last saw him alive on March 20 1945

Immediate cause of death	DURATION
Cachexia - abdominal	
d.t.a Carcinoma -	
Due to Abdominal Carcinoma -	
probably originating in pancreas	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ✓
Date of op.
Autopsy results: ✓
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ✓ Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ✓
Means of injury Injured at work?

23. SIGNATURE: Frederic J. Bartley M. D. or other
Address: Medical Arts Bldg - Balto Date signed 3-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (95)

Reg. Diat. No. 43

CERTIFICATE OF DEATH

02655

1. PLACE OF DEATH:

(a) County Balto.

(b) City or town Essex P.O. (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Philadelphia Rd.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 57yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Essex P.O. (If outside city or town limits, write RURAL and give town)

(d) Street No. Philadelphia Rd. (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Margaret Reich

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	divorced

6 (b) Name of husband or wife --

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 31, 1873

8. AGE: Years	Months	Days	If less than one day
71	11	23	____ hr. ____ min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Geo. Friedrich

13. Birthplace Germany

MOTHER

14. Maiden Name Annie Walz

15. Birthplace Germany

16 (a) Informant Mrs. Barbara Biddison

(b) Address Phila.Rd., Essex P.O., Md.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Mar. 27, 1945 (month) (day) (year)

(c) Cemetery or crematory Zion Lutheran

Location Stemmers Run, Md.

18 (a) Funeral director Loraine Funeral Home

(b) Address 7401 Belair Road

19 (a) 24-March (Date rec'd by registrar) (b) Mn. G. L. Reisinger Registrar

MEDICAL CERTIFICATION

20. Date of death March 23 1945, at 4:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to March 23 1945, and that I last saw him alive on March 23 1945.

Immediate cause of death	Duration
Cerebral apoplexy	Sudden
Due to Arteriosclerotic Cerebro-Vascular Disease	
Due to	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Geo. M. Baumgardner M. D. or other

Address Balto 6 Md Date signed 3/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02656

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 113 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Ft. Howard, Maryland

How long in hospital or institution? 113 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1004 W. Franklin St.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: ZESRO K. RICE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married--Sep.

6.(b) Name of husband or wife: ////// Edna Rice

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): 12-30-95

8. AGE: Years	Months	Days	If less than one day
49	2	4	....hrs. ....min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business:

FATHER — 12. Name: James Rice
13. Birthplace: Virginia

MOTHER — 14. Maiden name: Nannie ?
15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 13, '45 (month) (day) (year)

Cemetery or crematory: National

Location:

18. Funeral director: Mrs. Katie R. Williams

Address: 322 N. Schroeder St.

19. 3/13 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7, 1945, at 11:50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 14, 1945, to March 7, 1945 and that I last saw him alive on March 7, 1945

Immediate cause of death	DURATION
Carcinoma, esophagus, epidermoid	6 Mos.
	plus
Due to	
Due to	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: Biopsy, Jan. 23, 1945 Epidermoid, carcinoma Date of op.

Autopsy results: none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. J. KENNEY, M.D. CLINICAL DIRECTOR M. D. or other

Address: Fort Howard, Maryland Date signed: 3-8-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

P NC 02657

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Curtis Bay, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2125 Hawkins Point
(If rural, give LOCATION)

2.(a) If veteran, name war: WW - I

3. (a) FULL NAME: CHARLES F. ROBERTS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ///// Rita C. Roberts

6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): 10-5-1882

8. AGE:	Years	Months	Days	If less than one day
	62	5	2	....hrs. ....min.

9. Birthplace: Frederick, Maryland
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: William Roberts
13. Birthplace: LOndon

MOTHER — 14. Maiden name: Ann Renner
15. Birthplace: Frederick, Md.

18. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-13-45 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: A. Lee Oder
Address: 4644 York Road., Balto., Md.

19. 3/10 19 45 A. W. Hedrich per D
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8, 1945, at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5, 1945, to March 8, 1945 and that I last saw h... alive on March 8, 1945

Immediate cause of death	DURATION
Disease of the Heart:	1 Month
Coronary Arteriosclerosis; Myocardial	
Due to: ///// Insufficiency, auricular	
fibrillation, Class V.	
Due to:	
Other conditions: Ulcer, duodenal, active	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of: .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): .....

Means of injury: ..... Injured at work?

23. SIGNATURE: C. J. Kenney
C. J. KENNEY, M.D. CLINICAL DIRECTOR
M.D. or other
Address: Fort Howard, Maryland Date signed: 3-9-45

Rec'd U.S.
3/1/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

02658 37
Reg. Diat. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Texas
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 days
Hospital, Institution, or street address where death occurred:
Baltimore County Home
How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Philadelphia Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Frank Rose (Rubon)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6.(b) Name of husband or wife: Mrs Annie Rose
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 22, 1859

8. AGE:

Years	Months	Days	If less than one day
86	2	8	..... hrs. ..... min.

9. Birthplace: Italy (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Alexander Rubon
13. Birthplace: Italy

MOTHER
14. Maiden name: unknown
15. Birthplace: Italy

16. Informant: Mr. Albert Jones
Address: Essex - Philadelphia Road.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 2 1945 (month) (day) (year)
Cemetery or crematory: Oak Lawn Cemetery
Location: 7225 Eastern Ave.

18. Funeral director: John G. Connelly
Address: 3500 Bank St.

19. 3/3/45 (Date rec'd by registrar) Wm J. Whitcomb Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 1945 at 10:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/9 1945 to 3/30 1945 and that I last saw h... alive on 3/30 1945

Immediate cause of death	DURATION
Endocarditis	14 yr.
Due to: Nephritis —	
Due to: Arteriosclerosis —	
Other conditions: Senility.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

SIGNATURE: Holmes C. Evans M.D. M. D. or other
Address: Catonsville Md. Date signed: 3/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

02659

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 62 years
Hospital, institution, or street address where death occurred:
8305 Old Harford Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8305 Old Harford Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: CAROLINE H. ROTHFUSS

3.(b) Social Security Number: **

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Wm. Rothfuss
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 13th, 1874

8. AGE: Years	Months	Days	If less than one day
70	3	16	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Christian Zinn
13. Birthplace: Germany

MOTHER
14. Maiden name: Fredericka ----
15. Birthplace: Germany

16. Informant: Mr. Wm. Rothfuss
Address: 8305 Old Harford Road

17. burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 2, 1945 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Balto., Md.

18. Funeral director: Lacoste Funeral Home
Address: 7401 Belair Road

19. Mar. 30 1945 (Date rec'd by registrar) A. M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29th 1945, at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22 1945, to March 29 1945
and that I last saw h.. alive on March 29 1945

	DURATION
Immediate cause of death: Cerebral hemorrhage	1 wk.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: A. M. Bacon M.D. (M. D. or other)
Address: 2810 Taylor Ave. Date signed: 3/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

02660

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 262 Ridge Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Henry Lee Ruhl

3.(b) Social Security Number: 220-03-8857

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 18, 1897

8. AGE: Years	Months	Days	If less than one day
47	2	25	hrs. min.

9. Birthplace: Balto. Co., Maryland
(Town, county, and state)
10. Usual occupation: Drill Press Operator
11. Industry or business: Black & Decker Mfg. Co.

FATHER
12. Name: Robert Henry Ruhl
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annie Lee
15. Birthplace: Md.

16. Informant: Annie Lee Ruhl
Address: 262 Ridge Ave, Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 14 1945 (month) (day) (year)
Cemetery or crematory: Fairview Meth. Cem.
Location: Sunnybrook, Balto. Co. Md.

18. Funeral director: John Burns & Sons
Address: Towson, Md.

19. Mar. 14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12 1945, at 12-38 M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ 19 to 19
and ~~that I last saw him~~ alive on 19

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. G. Thurston Jr. M. D. or other
Address: Pikesville Md. Date signed: Mar 12 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

02661

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Victory Villa, Baltimore (20) (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 months

Hospital, Institution, or street address where death occurred:
4 Slipstream Court

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Victory Villa, Baltimore (20) (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4 Slipstream Court
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Rupert, Rebecca Jeanette

3.(b) Social Security Number: 173-07-7453

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Archie Rupert

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): February 27, 1896

8. AGE: Years	Months	Days	If less than one day
49		26	..... hrs. ..... min.

9. Birthplace: Bloomsburg, Columbia, Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: John Haynes

FATHER — 13. Birthplace: Missouri

MOTHER — 14. Maiden name: Ida May Cramer

MOTHER — 15. Birthplace: Bloomsburg, Pa.

16. Informant: George H. Wagner

Address: 4 Slipstream Court

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-28-45 (month) (day) (year)

Cemetery or crematory: Pine Rock Cemetery

Location: Montoursville, Pa.

16. Funeral director: A. Lee Adler

Address: 4644 York Rd.

19. ..... 19..... (Date rec'd by registrar) Cornelius Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26 1945 at 6 55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on Dead on arrival (Over) 19.....

Immediate cause of death	DURATION
Carcinomatosis	
Due to: Carcinoma of breast -	? 6 months
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Roy I. Bigham Jr M.D.
M. D. or other

Address: 947 N. Broadway Baltimore (5) Md. Date signed 3/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Note: Attending physician, Dr. H. L. Fuller, Ridge Rd, Baltimore (26) Md, out of town. I had not seen case prior to death, but had seen case record. Nurse in attendance at time of death.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02662

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 16 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 4 months, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore-30
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1710 Belt Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Cecelia Ryder

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William Ryder
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 1869?

8. AGE: Years: 75? Months: Days: If less than one day: ____ hrs. ____ min.

9. Birthplace: Ireland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: Michael Barrett
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Flynn
15. Birthplace: Ireland

16. Informant: Hospital records
Address: Baltimore-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-10-45 (month) (day) (year)
Cemetery or crematory: Cathedral
Location: Balto., Md.
18. Funeral director: Flynn & Fleming
Address: 1426 Light St.

19. 3/8 1945 (Date rec'd by registrar) H. C. Andrews Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7, 1945, at 12:30 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19, 1944, to March 7, 1945
and that I last saw her alive on March 7, 1945

	DURATION
Immediate cause of death: Broncho pneumonia	3 days
Due to: Chronic myocarditis	unknown
Due to: Arteriosclerotic reno-vascular disease	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury: ____ Injured at work?

23. SIGNATURE: Robert E. Gardner M.D. M. D. or other
Address: Catonsville, Balto.-28 Md. Date signed: 3/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02663

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 3 mos., 7 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs., 3 mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2924 Liberty Parkway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Catherine E. Sachs

3. (b) Social Security Number: # Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William T. Sachs
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): August 24, 1913

8. AGE: Years	Months	Days	If less than one day
31	7	2	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Secretary
11. Industry or business
FATHER 12. Name: William J. Deems
FATHER 13. Birthplace: Baltimore, Maryland
MOTHER 14. Maiden name: Elizabeth Dranbeaur
MOTHER 15. Birthplace: Baltimore, Maryland
16. Informant: Mrs. Catherine E. Sachs
Address: 2924 Liberty Pkwy., Dundalk, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 29, 1945 (month) (day) (year)
Cemetery or crematory: New Cathedral Cemetery
Location: 520 N. Charles St., Balto., Md.
18. Funeral director: J. C. Miller, Inc.
Address: 2435 E. Oliver St., Balto., Md.
19. Mar. 26, 1945 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26, 1945, at 6:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 19, 1944, to March 26, 1945; and that I last saw her alive on March 26, 1945.

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	7 mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Tuberculous Laryngitis	4 mos.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Stewart A. Shaffer M.D. M. D. or other
Address: Mount Wilson, Md. Date signed: 3/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

02664

CERTIFICATE OF DEATH

Reg. Dist. No. 42

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Rosemount (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 3002 Alabama Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Baltimore
City or town Rosemount (If outside city or town limits, write RURAL and give nearest town)
Street No. 3002 Alabama Ave. (If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME MOSBEY LEE SAUNDERS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Emma
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1864

8. AGE: Years	Months	Days	If less than one day
80	7	5	..... hrs. ..... min.

8. Birthplace Va. (Town, county, and state)
10. Usual occupation Salesman
11. Industry or business

FATHER
12. Name Augustus Saunders
13. Birthplace Va.

MOTHER
14. Maiden name Mary Sands
15. Birthplace N.Y.

18. Informant Emma Saunders
Address 3002 Alabama Ave., Rosemount, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3/16/45 (month) (day) (year)
Cemetery or crematory St. Johns
Location Warsaw, Va.
18. Funeral director William Cook, Inc.
Address 1217 St. Paul St. Baltimore, Md.

19. 3/15 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 19 7:45PM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/1 45 19 ..... to 3/13 19 45 and that I last saw h.i.m alive on 3/13 19 45

Immediate cause of death	DURATION
Pneumonia - Bronchial	2 weeks
Due to	
Due to	
Other conditions Senile (Include pregnancy within 3 months of death)	

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE Paul Schuyler M. D. or other
Address 3 Ba. summit Date signed 3/14 19 45

G27405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27405
Registered No. 02665

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: Co.
(a) Baltimore ~~City~~, Maryland
(b) Street address 119 Belmar Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Raspeburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 Belmar Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick W. Schnepf

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 217-05-8433

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E. Schnepf

6 (c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): July 27, 1888

8. AGE: Years: 56 | Months: 8 | Days: — | If less than one day: hr. min.

9. Birthplace: Baltimore County
(Town, county, and state)

10. Usual Occupation: Engineer

11. Industry or business

FATHER
12. Name: John G. Schnepf
13. Birthplace: Germany

MOTHER
14. Maiden Name: Prescilla Druhpfer
15. Birthplace: Princess Ann, Md.

16 (a) Informant: Mrs Mary E. Schnepf
(b) Address: 119 Belmar Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-45 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location:

18 (a) Funeral director: Frederick A. Cole
(b) Address: 1200 W. Lombard St.

19 (a) MAR 31 1945 (Date received by registrar) (b) Registrar: Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27, 1945, at 3.25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1943, to Mar 27 1945, and that I last saw h[illegible] alive on Mar 27 1945.

Immediate cause of death: Chronic Pulmonary Fibrosis — Duration:
Due to: Bronchitis
Due to: Asthma Emphysema
Other Conditions: Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Walter A Anderson M. D.
Address: 300 Lemmon Bldg. Date signed: 3/30/45

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02666

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs., 8 mos., 17 das.

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 6 yrs., 8 mos., 17 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1442 E. Baltimore Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Fannie Schoen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December, 1865

8. AGE: Years	Months	Days	If less than one day
79	3	?	hrs. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: ?

FATHER — 13. Birthplace: ?

MOTHER — 14. Maiden name: ?

MOTHER — 15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville, Baltimore-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mch 9-1945 (month) (day) (year)

Cemetery or crematory: Herring Run

Location: Boley's Lane

18. Funeral director: Jack Lewis Inc.

Address: 1436 E. Balto. St.

19. 3/9 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9 19 45 at 12:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 19 38, to March 9 19 45 and that I last saw her alive on March 9 19 45

Immediate cause of death	DURATION
Coronary occlusion	6 hrs.
Due to: Generalized arteriosclerosis	Indef.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D. M. D. or other

Robert E. Gardner, M.D.

Address: Catonsville, Balto.-28, Md. Date signed: 3/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02667

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 821 Frederick Ave,

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Emma Lavinia Schotta

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

8.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 6, 1873

8. AGE:

Years	Months	Days	If less than one day
71	3	23	..... hrs. ..... min.

9. Birthplace: Catonsville, Md. (Town, county, and state)

10. Usual occupation: Household duties

11. Industry or business: At home

FATHER

12. Name: John Henry Schotta

13. Birthplace: Maryland

MOTHER

14. Maiden name: Emma Henrietta Platt

15. Birthplace: Maryland

16. Informant: Miss Edna E. Schotta

Address: 821 Frederick Ave. Catons.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 3 1945 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore, Md.

18. Funeral director: Easton Sons

Address: 608 Frederick Ave Catons. Md

19. 3/2 1945 (Date rec'd by registrar) W. C. Andrepe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 1st. 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec, 27 er 1935 to March, 1 1945 and that I last saw h... alive on March, 1 1945

Immediate cause of death	DURATION
Lobar Pneumonia.	8 days
Due to: Chr. Myocarditis.	10 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: 0

Date of op.

Autopsy results: 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following:

Accident, suicide, or homicide: 0 Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: 0 Injured at work?

23. SIGNATURE: D. Lloyd Johnson M. D. or other

Address: Catonsville, Md. Date signed 3-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 026684

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 hours

Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 29 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: James Sevick Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ///// Mary Sevick

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): October 11, 1892

8. AGE:	Years	Months	Days	If less than one day
	52	6	20	....hrs. ....min.

9. Birthplace: Curtis Bay, Maryland
(Town, county, and state)

10. Usual occupation: Electrician

11. Industry or business

FATHER
12. Name: James
13. Birthplace: Austria

MOTHER
14. Maiden name: Anna Posavad
15. Birthplace: Austria

18. Informant: Mrs. Mary Sevick

Address: Walnut & Severna Ave. Chesaco Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/4/45 (month) (day) (year)

Cemetery or crematory: xxxx Baltimore National

Location: Catonsville, Balto. Md.

18. Funeral director: Charles E. Schimunek

Address: 2601 E. Madison Street

19. 4/3/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31, 1945 at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30, 1945 to March 31, 1945 and that I last saw him alive on March 31, 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	4 days
Due to	
Due to	
Other conditions: Bronchial asthma	5 years

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. P. Richards acting Clinical Director M. D. or other

Address: Fort Howard, Maryland Date signed: 4/1/45

Dr. Hummel
Essex
417½ Eastern Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02669 P

Reg. Diat. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Cape May Beach
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cape May Beach
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Emmanuel Victor Shivers **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Albertina Lavender
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 23-1871

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
73	3	6		

9. Birthplace: Baltimore - Md. (Town, county, and state)
10. Usual occupation: retired
11. Industry or business
FATHER 12. Name ✓
FATHER 13. Birthplace ✓
MOTHER 14. Maiden name ✓
MOTHER 15. Birthplace ✓
16. Informant: Mrs. H. J. Molloy
Address: Cape May Beach
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-31-45 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Baltimore
18. Funeral director: Leonard J. Ruck
Address: 5305 Harford Road
19. 3/31/45 (Date received by registrar) C. W. Helfrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29 1945 at 7.00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 25 1944 to March 29 1945 and that I last saw her alive on March 29 1945

	DURATION
Immediate cause of death: Acute Coronary occlusion	1 day
Due to: Arteriosclerosis	5 Yr.
Due to:	
Other conditions: Hypertension	3 Yr.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward N. Hummel M. D. or other
Address: 417½ Eastern Ave. Date signed: 3/31/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Rec'd. U.S.
3/31/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

02670 P

CERTIFICATE OF DEATH

Reg. Diat. No. 38

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 819 Regester Ave (Deceased nursing home)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. The Jefferson Apts Apt 3208
(If rural, give LOCATION)
2.(a) If veteran, name war W

3.(a) FULL NAME Fannie Grace Shaw

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 15th

8. AGE: About 89 Years | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Charles H Shaw

13. Birthplace Baltimore Md

MOTHER 14. Maiden name M Smith

15. Birthplace Baltimore Md

16. Informant Grace E Shaw

Address The Jefferson Apts

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/6/45 (month) (day) (year)

Cemetery or crematory Loudon Park

Location Baltimore Md

16. Funeral director Wilson Cook Inc

Address 1217 E Lanvale St

19. 3/6 1945 (Date rec'd by registrar) G. W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1945, at 11:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1940 to March 3 1945 and that I last saw h.e.r alive on March 2, 1945

	DURATION
Immediate cause of death Lobar pneumonia	
Due to Following Hemiplegia (Lt)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE Amos L. Hutchins M. D. or other

Address 1227 Calvert St Date signed March 5, 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd U.S.
3/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

02671 P

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years, 5 months, 3 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 20 years, 5 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Bay View Hospital
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: James T. Shutt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: no
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 26, 1883

8. AGE: Years	Months	Days	If less than one day
61	7	23	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: none
11. Industry or business: none

FATHER
12. Name: John C. Shutt
13. Birthplace: unk.

MOTHER
14. Maiden name: Mathilda Brown
15. Birthplace: unk.

16. Informant: Hospital Records
Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-24-45 (month) (day) (year)
Cemetery or crematory: Baltimore Cem
Location: North Ave
16. Funeral director: John C. Nulley Sons
Address: 2409 E. Oliver St

19. 3/22/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 19 45 at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18 19 24 to March 21 19 45 and that I last saw him alive on March 21 19 45

Immediate cause of death	DURATION
Acute Myocardial Insufficiency	4 days
Due to: Chonic Arteriosclerotic Cardiovascular Disease	Indef.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robert E. Gardner M. D. or other
Address: Catonsville, 28, Md. Date signed: 3/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

Rec'd U.S.
3/24/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

02672 P

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:
County Balto.
City or town
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 2 Fullerton Hights Ave
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 2 Fullerton Hights Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary B. Sinclair

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6 (b) Name of husband or wife John A. Sinclair
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 26 1879

8. AGE: Years	Months	Days	If less than one day
65	2	8	hrs. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual occupation At Home
11. Industry or business
FATHER 12. Name Joseph Zelenka
13. Birthplace Md.
MOTHER 14. Maiden name Anna Student
15. Birthplace Md.
16. Informant Mrs. M. Rassa (Sister)
Address 2 Fullerton Hights Ave (6)
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 7 45 (month) (day) (year)
Cemetery or crematory Lorraine Park
Location 5600 Dogwood Rd.
18. Funeral director Martin W. E. Pippel Sons
Address 2110 Belair Rd
19. 3/6 1945 (Date rec'd by Registrar) C. W. Kubicki Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1945, at 7:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1945, to March 4 1945
and that I last saw h- alive on 3/3 1945.

Immediate cause of death	DURATION
Acute Cardiac dilatation	24 hrs.
Hypostatic Pneumonia	1 week
Due to Cerebral Hemorrhage	1 mo.
Chronic Myocarditis	?
Due to Arteria Sclerotic &	?
Hypertensive Cardiovascular	?
Other conditions disease	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Anthony J. Thomas M. D. or other
Address 4600 York Rd Date signed 3/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd U.S.
3/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 02673

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and lucidly.

VS A15

1. PLACE OF DEATH:
County: Balto
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
13 Linden Terrace
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 13 Linden Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Helen L. Sommer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

8.(b) Name of husband or wife: Herman Joseph Sommer
8.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Dec 1st 1883

8. AGE: Years	Months	Days	If less than one day
61	3	13	hrs. min.

9. Birthplace: Jersey City N. J. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Philip Warn
13. Birthplace: Alsace - Lorraine

MOTHER
14. Maiden name: Margaret Wagner
15. Birthplace: Germany

18. Informant: A. Evelyn Sommer
Address: 13 Linden Terrace

17. (Burial, cremation, or removal. Which?) Removal Date thereof: 3/15/45 (month) (day) (year)
Cemetery or crematory: Vernay City N. J.
Location:
18. Funeral director: William Cook Inc
Address: 127 St Paul St

19. (Date rec'd by registrar) 3/15 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 14th 1945 at 4 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb-13- 1945 to Mch-14- 1945 and that I last saw her alive on Mch 13- 1945

Immediate cause of death	DURATION
Edema of Lungs -	1 day.
Due to: Mitral Stenosis	5 yrs
Due to: Chronic Myocarditis	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. Gill Hall M.D. M. D. or other
Address: 1631 E. North ave Date signed: Mch-14-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-E)

CERTIFICATE OF DEATH

02674

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Essex (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 Months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Essex (If outside city or town limits, write RURAL and give nearest town)

Street No. 8132 Gough St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ADELINA SORGE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~wife~~: Pasquale Sorge

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 25 1892

8. AGE: Years	Months	Days	If less than one day
53	1	22	hrs. min.

9. Birthplace: Montorio Al Vomano (Italy) (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER 12. Name: Giuseppe De Angelis

FATHER 13. Birthplace: Italy

MOTHER 14. Maiden name: Amerena Pellanera

MOTHER 15. Birthplace: Italy

16. Informant: Mary Celani (Daughter)

Address: 8132 Gough St. Essex Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 19/45 (month) (day) (year)

Cemetery or crematory: Oak Lawn Cemetery

Location: 7225 Eastern Ave

18. Funeral director: Frank Della Rocca

Address: 52 N. Morley St. Baltimore Md.

19. March 17 1945 (Date rec'd by registrar) John S. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16 1945, at 9.50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1945 to March 16 1945 and that I last saw h~~er~~ alive on March 16 1945

Immediate cause of death	DURATION
Carcinoma of stomache	11/2 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Leonard M. Hummel M. D. or other

Address 417½ Eastern Ave Date signed 3/17/45

M

I

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

02675

CERTIFICATE OF DEATH

Reg. Diat. No. 40

1. PLACE OF DEATH:

County: Baltimore

City or town: Notch Cliff near Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Notch Cliff near Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sister Mary Ositha Spross

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 8, 1863

8. AGE: Years	Months	Days	If less than one day
81	11	3	..... hrs. ..... min.

9. Birthplace: Churchville, N.Y. Monroe Co.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: Joseph Spross
13. Birthplace: Bavaria

MOTHER
14. Maiden name: Phillippina Halsa
15. Birthplace: Prussia

16. Informant: Sr. Mary Clara

Address: Notch Cliff Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 13/45 (month) (day) (year)

Cemetery or crematory: Notch Cliff

Location: Glen Arm Md

18. Funeral director: Geo M. Franz & Son

Address: 811 N. Wolfe St.

19. 3/12/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11 1945, at 4:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 26 1941, to March 11 1945 and that I last saw h.er alive on March 7 1945

Immediate cause of death: Lobar Pneumonia	DURATION: 3 weeks
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findiegs of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Kurt Strauss M. D. or other

Address Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

02676

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Cockeysville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs

Hospital, institution, or street address where death occurred: Masonic Home

How long in hospital or institution? 5 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3926 Dunnell Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Howard Clinton Standiford

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mary Cynthia Standiford

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 12 - 1872

8. AGE: Years	Months	Days	If less than one day
72	8	4	hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Night Watchman

11. Industry or business:

FATHER — 12. Name: Isaac C. Standiford

FATHER — 13. Birthplace: Baltimore Md

MOTHER — 14. Maiden name: Henrietta Zimmer

MOTHER — 15. Birthplace: England

16. Informant: Laura M. Schroeder

Address: Masonic Home, Cockeysville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 20 - 45 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Md

18. Funeral director: Geo. L. Boyd Jr.

Address: 1512 Hollins St.

19. 3-19 19 45 Wilmer C. Ensor

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 16 19 45 at 11 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 19 40 to Mar 16 19 45

and that I last saw h alive on Mar 15 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to Hypertensive Cardio	
Due to Vascular Desease	5 yrs
Other coodilions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Walter F. Shillman M.D.

M. D. or other

Address: 6 Biddle St Date signed: 3/17/45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (170-2)

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Sparrows Pt. Hway. air Reduction Corp. (scene of accident)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town ..... (If outside city or town limits, write RURAL and give town)
(d) Street No. 2508 Sycamore Ave. (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Willie Stern

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) .....

8. AGE: Years	Months	Days	If less than one day
30			..... hr. ..... min.

9. Birthplace Orange Co. Virginia (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name James Stern
13. Birthplace Va.

MOTHER
14. Maiden Name Polly Yancy
15. Birthplace Va

16 (a) Informant James Stern
(b) Address 2503 Sycamore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 / 18 / 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County

18 (a) Funeral director Raynor Sanders
(b) Address 1412 E. Preston Street

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1945, at 10 P. M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-12-45 at between 4:30 & 10 P. M.
(b) Where did injury occur? air Reduction Corp. (Hway) Sparrows Pt & Edgemere
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by auto.

23. Signature Robert C. Graham M.D. (Medical Examiner.)
Date signed March 15 1945

VS 151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02678

Reg. Dist. No. 4V

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Facility, Ft. Howard, Maryland

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ~~Baltimore~~

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3722 Greenmount Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war: SAW ✓

3.(a) FULL NAME: GEORGE ALBERT STONE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Widowed

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 9-5-70

8. AGE:	Years	Months	Days	If less than one day
	74	6	17	..... hrs. ..... min.

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation: Iron Moulder

11. Industry or business

FATHER — 12. Name: Thomas Stone
13. Birthplace: England

MOTHER — 14. Maiden name: Mirah Anderson
15. Birthplace: England

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/24/45 (month) (day) (year)

Cemetery or crematory: Baltimore National Cem.

Location: Baltimore, Md.

18. Funeral director: William J. Tickner & Son

Address: Baltimore, Md.

19. 3/23 19 45 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 19 45, at 1:55 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 19 45, to March 22 19 45 and that I last saw him alive on March 22 19 45

Immediate cause of death	DURATION
Atelectasis, left lung	6 mos.
Due to: Aneurysm, Aorta	Unknown
Due to: Syphilis	Unknown
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: None ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. J. Kenney
C. J. KENNEY, M.D., CLINICAL DIRECTOR
M. D. or other

Address: Fort Howard, Maryland Date signed: 3-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02679

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 103 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Facility, Ft. Howard, Maryland
How long in hospital or institution? 103 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County:
City or town: Midlothian
(If outside city or town limits, write RURAL and give nearest town)
Street No. - -
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-1

3.(a) FULL NAME: ERNEST CAMERON STOVER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Divorced
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 7-14-1889

8. AGE: Years	Months	Days	If less than one day
56	8	10	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business:
FATHER 12. Name: Frank
13. Birthplace: Virginia
MOTHER 14. Maiden name: Viola Jones
15. Birthplace: Virginia
16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-28-45 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington Va
18. Funeral director: A. Lee Oder
Address: 644 York Rd.
19. 3/27/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24 19 45 at 12:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 11 19 44 to March 24 19 45 and that I last saw h. im alive on March 24 19 45

Immediate cause of death	DURATION
Coronary arteriosclerotic heart disease with cardiac hypertrophy, myocardial damage and insufficiency. Class IV.	6 mos. plus
Due to	
Due to	
Other conditions: Hernia, inguinal, bilateral maxillary sinusitis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work? No

23. SIGNATURE: C. J. Kenney
C. J. KENNEY, M.D., CLINICAL DIRECTOR
Address: Fort Howard, Maryland Date signed: 3-24-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02680

Reg. Dist. No. 34

1. PLACE OF DEATH

County: Baltimore

City or town: Brooklyneville – Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Brooklyneville (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lydia M Streving

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

8.(b) Name of husband or wife: Harry M Streving

8.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Oct 29 – 1868

8. AGE:

Years	Months	Days	If less than one day
76	4	25	...hrs. ...min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John M Bond
13. Birthplace: Md

MOTHER
14. Maiden name: Elizabeth Pauler
15. Birthplace: Md

16. Informant: Harry M Streving
Address: Hampstead Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 27/45 (month) (day) (year)

Cemetery or crematory: Grave Run

Location: Balto Co

18. Funeral director: Edw C Tipton

Address: Hampstead Md

19. Mch 26 19 45 (Date rec'd by registrar) Paul E. Forth M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24th 19 45 at 12 1 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9th 19 45 to March 24 19 45

and that I last saw h alive on on March 23rd 19 45

Immediate cause of death	DURATION
Tuberculosis of Lungs	10 yrs
Due to	
Due to	
Other conditions: advanced age Fracture of Dr colyda	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: D M Resh M.D.
M. D. or other

Address: Hampstead Md Date signed: 3/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(12)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02681

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Vets. Adm. Facility, Fort Howard, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 438 W. Biddle St.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-1 ✓

3. (a) FULL NAME: ISAAC STURGES

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Mrs. Beulah Sturges
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-2-1895

8. AGE: Years	Months	Days	If less than one day
49	6	23	hrs. min.

9. Birthplace: Sparrows Pt. Maryland
(Town, county, and state)

10. Usual occupation: Unemployed
11. Industry or business

FATHER
12. Name: John Sturges
13. Birthplace: Chester, Pa

MOTHER
14. Maiden name: Josephine Sturges
15. Birthplace: Virginia

16. Informant: Vets. Adm. Fac. Fort Howard, Maryland
Address: Ft. Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-28-45 (month) (day) (year)
Cemetery or crematory: National Cem
Location: Baltimore, Md
18. Funeral director: Samuel T. Hemsley
Address: 578 W. Biddle St., Balto., Md.

19. 3-26 (Date rec'd by registrar) 19 45 John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25 19 45, at 2:15 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12, 1945, to March 25, 1945 and that I last saw h... in... alive on March 25, 1945

Immediate cause of death	DURATION
Exsanguination	1 Hour
Due to: Esophageal Varices	1 Month plus
Due to: Cirrhosis of Liver	1 Yr. plus
Other conditions: Gumma of Liver, Gumma of Spleen	

(Include pregnancy within 3 months of death)

Major findings of operations: no Operations
Date of op.
Autopsy results: Substantiated above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: C. J. Kenney, M.D. CLINICAL DIRECTOR
Address: Fort Howard, Maryland. Date signed: 3-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

CERTIFICATE OF DEATH

02682

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Balto

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 15 Roberts ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 15 Roberts ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: William Henry Tate

3. (b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
M	Col	Widowed

8.(b) Name of husband or wife:

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 21 1882

8. AGE: Years: 62 6 | Months: | Days: 8 | If less than one day: hrs. min.

9. Birthplace: Ala (Town, county, and state)

10. Usual occupation: Just Dealer

11. Industry or business:

FATHER — 12. Name: Tilton Tate

13. Birthplace: Ala

MOTHER — 14. Maiden name: Annie ?

15. Birthplace: Ala

16. Informant: Arthur Tate

Address: 29 Harvard Place Lyne Ky

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/23/45 (month) (day) (year)

Cemetery or crematory: Western Star

Location: Balto County Md

18. Funeral director: Chas. Gaither

Address: 512 Carroll Ave

19. (Date rec'd by registrar): 3/23 1945 — A. W. Hedrich, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20 19 45 at about 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Apoplexy	
Due to: Cerebro vascular disease	
Due to: sudden death	
Other conditions: Injury	

(Incinde pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo. M. Kieffer Kept Med Exam Balto

M. D. or other

Address: 1010 Leadenhall Date signed: 3-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Surg Simon

Rec'd. U.S., 3/23/45

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-D)

CERTIFICATE OF DEATH

02683 P

Reg. Dist. No. 33

1. PLACE OF DEATH

County Balto.

City or town Reisterstown, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Balto.

City or town Reisterstown, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Bond ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Eliza Jane Thompson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	colored	Widowed

6.(b) Name of husband or wife Nimrod Thompson (dec'd)

6.(c) If alive, give age ..... years

7. Birth data of deceased (mo., day, yr.) Feb. 22, 1863

8. AGE: Years	Months	Days	If less than one day
82			hrs. min.

9. Birthplace Chestnut Ridge, Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Jacob Parker

13. Birthplace Not Known

MOTHER 14. Maiden name Blinda Smith

15. Birthplace Not Known

16. Informant Mrs Estelle Jones

Address Bond ave. Reisterstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/10/45 (month) (day) (year)

Cemetery or crematory St. Lukes

Location Reisterstown, Md.

18. Funeral director Wm. J. Chatman Jr.

Address 6099 Prescott ave. Balto. Md.

19. 3/9 1945 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 7 1945, at 8 a. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1 1941, to Mar 7 1945 and that I last saw her alive on Mar 6 1945

Immediate cause of death	DURATION
Arteriosclerosis	4 yrs.
Due to Chr. Interstitial Nephritis	3 yrs.
Due to Bronchitis	4 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None. Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. D. Eagles, M. D.
M. D. or other

Address Reisterstown Md Date signed 3-7-45

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (BC) Reg. Dist. No. 33

CERTIFICATE OF DEATH

02684

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Reisterstown (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution Int. Pleasant Sanatorium
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6mo 11days
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 131 W. Broadway (If rural give location)
(e) If foreign born, how long in U. S. A.? 38 years

3 (a) **FULL NAME** Dora Dinfanoff (Tenanoff)

3 (b) If veteran, name war | 3 (c) Social Security No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 15, 1880

8. AGE: Years 65 | Months 1 | Days 9 | If less than one day ____hr. ____min.

9. Birthplace Bobruisk, Russia (Town, county, and state)

10. Usual occupation Housework.

11. Industry or business

FATHER
12. Name Moishe Cohen
13. Birthplace Russia

MOTHER
14. Maiden Name Dora Bottyloff
15. Birthplace Russia

16 (a) Informant Anne Dinfanoff (Daughter)
(b) Address 131 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Balto St

19 (a) 3/24/45 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. Date of death March 24, 1945, at 1.19 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13, 1944, to March 24, 1945, and that I last saw him alive on March 24, 1945.

Immediate cause of death	Duration
Myocardial Collapse	
Due to Pulmonary Tuberculosis	35 years
Due to Diabetes mellitus	6 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert J. Shuer M.D. (M. D. or other)
Address Reisterstown, Md Date signed March 24, 1945

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VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (26)

CERTIFICATE OF DEATH

02685

Reg. Dist. No. 30

7

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2 University Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William E. Towns.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Annie D. Towns.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 26, 1857

8. AGE:

Years	Months	Days	If less than one day
87.	10	10	..... hrs. ..... min.

9. Birthplace: Pa. (Town, county, and state)

10. Usual occupation: Insurance Agent

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace: Unknown

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Elmer A. Towns

Address: 3910 Hayward Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 6, 1945 (month) (day) (year)

Cemetery or crematory: London Park

Location: City

18. Funeral director: Mr. & Mrs. John W. Tindel & Son

Address: 804 W. Fayette St.

19. Mar 5 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 3 1945, at 9.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1940, to Mar 3 1945

and that I last saw h.. alive on Mar 3 1945

Immediate cause of death	DURATION
Congestive Heart Failure	1 hr
Due to: Arteriosclerosis	?
Due to: Mitral Valvular Disease	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wilson K. Gallagher M.D. M. D. or other

Address: Catonsville 28, Md. Date signed: 3-5-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3)-a

02686

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Allegany
City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Dorchester Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Henry F. Vogel

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife Salome A. Fisher
6.(c) If alive, give age 56 years
7. Birth date of deceased (mo., day, yr.) 10/9/1867

8. AGE: Years	Months	Days	If less than one day
77	5	2	hrs. min.

9. Birthplace Brooklyn N.Y.
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business —
FATHER 12. Name Charles Vogel.
13. Birthplace N.Y.
MOTHER 14. Maiden name —
15. Birthplace N.Y.
16. Informant Salome A. Fisher
Address Dorchester Rd Catonsville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/14/45 (month) (day) (year)
Cemetery or crematory London Park
Location Baltimore Md.
18. Funeral director F. J. Wisseart, Inc.
Address 300 Eutaw Place
19. 3/12 19 45 (Date rec'd by Registrar) H. C. Andrews Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12th 1945 at 6:30 M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar. 1. 1945 to Mar. 12 1945
and that I last saw him alive on 3-11- 1945

Immediate cause of death — DURATION

Chronic Myocarditis. several years
Due to Chronic Interstitial Nephritis. several years
Other conditions Old Age.
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm Levi C. Blake MD
M. D. or other
Address Med. Arts Bldg. Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (26)

CERTIFICATE OF DEATH

02687 P

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Balto.

City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
107 Shealey Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro iofants give residence of mother)

State: Md. County: Balto.

City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 107 ShealeyAve.
(If rural, give LOCATION)

2.(a) If veleran, name war

3.(a) FULL NAME

EMMA M. WARNER

3.(b) Social Security Number

--

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 26, 1865

8. AGE: Years	Months	Days	If less than one day
79	3	21	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: Christian Warner
13. Birthplace: Md.

MOTHER
14. Maiden name: Anna Baltz
15. Birthplace: Md.

16. Informant: Miss Annie B. Warner
Address: 107 Shealey Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/20/45 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 3/20 19 45 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17, 1945, at 2:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 1945 to March 17 1945

and that I last saw h... alive on March 17 1945

	DURATION
Immediate cause of death	
Hemorrhage of	7 hrs.
Due to: Mitral Endocarditis	unknown
Due to: Senility	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. B. Enson M. D. or other

Address: 7201 York Rd Date signed: 3-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 07

02688

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Balto Co
City or town: Hyde Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto.
City or town: Hyde Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary H. Warner

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 15 - 1857

8. AGE: Years: 87 | Months: 6 | Days: 22 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Wheeling West Va.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Daniel C. Fast
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Mary Hanna
15. Birthplace: Wheeling W. Virginia

16. Informant: Mrs. Alfred Smithpeter
Address: Hyde Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Mar 12 - 1945
(month) (day) (year)

Cemetery or crematory: Greenmount
Location: Balto City Md.

19. Funeral director: Clarence E. Cathell
Address: Fork Md.

19. Mar 11 1945
(Date rec'd by registrar)
C. E. Cathell
Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10 1945, at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9 1945 to March 10, 45.
and that I last saw h.r alive on March 9, 1945.

Immediate cause of death: Acute Bronchio Pneumonia — DURATION: 2 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clifford F. Hudson M.D.
M. D. or other
Address: Fork, Md. Date signed: 3/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02689

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 44 Days

Hospital, Institution, or street address where death occurred:

Vets. Adm. Facility, Fort Howard, Maryland

How long in hospital or institution? 44 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 730 S. Broadway

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-1 ✓

3. (a) FULL NAME JOHN WARYASZ
JOHN WARYAS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Widowed

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 11-20-1898

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
46	4	5		

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER — 12. Name: John Maryas
13. Birthplace: Poland

MOTHER — 14. Maiden name: Julia (M.N. unknown)
15. Birthplace: Poland

16. Informant: Clinical Records, Vets. Adm. Fac.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 28/45 (month) (day) (year)

Cemetery or crematory: Holy Rosary

Location: Baltimore

18. Funeral director: Fred W. Oszazewski

Address: 1930 Eastern Ave.

19. 3/26/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25, 19 45, at 11:15a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 9, 19 45 to March 25, 19 45 and that I last saw h im alive on March 25, 19 45

Immediate cause of death	DURATION
Tuberculosis, chronic far advanced active	6 weeks plus
Due to	
Due to	
Other conditions: Cirrhosis of Liver, hypertrophic.	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: not done.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: C.J. KENNEY, M.D., CLINICAL DIRECTOR

Address: Fort Howard, Maryland Date signed: 3-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (94a)

02690 31 P

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Baltimore

(b) City or town Woodlawn
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:
3610 Rockdale Terrace

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Woodlawn
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3610 Rockdale Terrace
(If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Gurldy A. Webster

3 (b) If veteran, name war

3 (c) Social Security No. 220-07-3606

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Pearl V. Webster

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 23, 1885

8. AGE: Years	Months	Days	If less than one day
59	4	18	____hr. ____min.

9. Birthplace Carroll County, Md.
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER
12. Name Luther Webster
13. Birthplace Carroll County, Md.

MOTHER
14. Maiden Name Mary Bloom
15. Birthplace Carroll County, Md.

16 (a) Informant Mr. Douglas S. Webster
(b) Address 8050 Liberty Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 14, 1945 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cemetery

Location Woodlawn, Md.

18 (a) Funeral director Phillips Funeral

(b) Address 4510 Liberty Heights Ave.

19 (a) 3/13/45 (Date rec'd by registrar) (b) ____ Registrar

MEDICAL CERTIFICATION

20. Date of death March 11 19 45, at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10 19 45 to 3-11 19 45

and that I last saw him alive on 3-10 19 45

Immediate cause of death	Duration
Coronary Occlusion	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thos J Robertson M. D. or other

Address 4509 Liberty Hgts Ave Date signed 3/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-4)

02691

P

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Sparrows Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Sparrows Point

(If outside city or town limits, write RURAL and give nearest town)

Street No. 725 E St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Julia Jeanette Webster

3.(b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Chas W. Webster

6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.): April 14th 1880

8. AGE: Years 64 Months Days If less than one day ... hrs. ... min.

9. Birthplace: Somerset Co Md (Town, county, and state)

10. Usual occupation: At home

11. Industry or business

FATHER 12. Name: Chas W White

13. Birthplace: Md

MOTHER 14. Maiden name: Julia Blenkinsett

15. Birthplace: Md

16. Informant: Chas W. Webster

Address: 725 E St. Sparrows Pt

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 19 1945 (month) (day) (year)

Cemetery or crematory: Oak Lawn Cem

Location: City

18. Funeral director: Hillcrest Funeral Home

Address: 200 E. Orleans St

19. 3/17 (Date rec'd by registrar) 45 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16 1945 at 4:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945 to March 16 1945

and that I last saw h alive on March 15 19 45

	DURATION
Immediate cause of death: Cancer of Bladder	2 yrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A B Lindsay, M.D. M. D. or other

Address: 500 E St Sparrows Pt Date signed: 3.16.45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-H)

CERTIFICATE OF DEATH

02692

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months + 14 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 5 months 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2303 E. Preston St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Richard J. Welsh

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 17, 1917

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
27	5	9		

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: odd job.

11. Industry or business:

FATHER — 12. Name: Richard Joseph Welsh
13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Mary Kane
15. Birthplace: Baltimore, Md.

16. Informant: Records Spring Grove State Hosp.
Address: Catonsville, Baltimore 28, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 30 45 (month) (day) (year)

Cemetery or crematory: New Cathedral Cem.
Location: Baltimore City

18. Funeral director: John M. Welsh
Address: 404 S. Chester Street

19. 3/29 45 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 26 1945, at A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Suicide – Gas Poisoning	1 da
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, ~~or homicide~~ Date of 3-26-'45
Where did injury occur? Spring Grove Hosp. (City or town) Balto. (County) Md. (State)
Injured at home, farm, industry, public place (where?) State Hospital
Means of injury Took Illuminating Gas. injured at work?

23. SIGNATURE: D. D. Eagles, M. D. (M. D. or other)
Address: Reisterstown, Md. Date signed: 3-27-'45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd. U.S.
3/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52

CERTIFICATE OF DEATH

62693

Reg. Dist. No. 37

1. PLACE OF DEATH:
County Baltimore
City or town Texas
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Baltimore County Home.
Stay in hospital or inst. (yrs., or mos., or days) 8 mo. 21 da.
Stay in this community (yrs., or mos., or days) 8 mo. 21 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of motber)
State Maryland. County Baltimore
City or town Texas Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Julian Wieneck

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Widowed

B (b) Name of husband or wife unknown

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
about 85			____ hrs. ____ min.

9. Birthplace Austria
(Town, county, and state)

10. Usual occupation Laborer Farm

11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden name Unknown
15. Birthplace "

16. Informant Baltimore Co., Home Register
Address Texas, Maryland.

17. Burial Date thereof Mar. 9, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Baltimore Co., Home
Location Texas Maryland

18. Funeral director Landon Brooks
Address Sparks. Maryland

19. Mar. 8 1945 Wm. J. Lockwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March. 8 1945, at 4 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1944, to March 8 1945,
and that I last saw him alive on 3/7 1945.

	DURATION
Immediate cause of death Benign Tumor of neck and Throat	1 yr.
Due to	
Due to	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Holmes C. Emerson M. D.
M. D. or other
Address Cockeysville Md Date signed 3/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

CERTIFICATE OF DEATH

02694

Reg. Dist. No. 42

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Dalesbrooke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs

Hospital, institution, or street address (where death occurred): 5512 Selma Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Dalesbrooke

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5512 Selma Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert L Wolf

3.(b) Social Security Number 215-10-8851

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Helen G Davis Wolf

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 7th 1902.

8. AGE: Years	Months	Days	If less than one day
43	2.	8	..... hrs. ..... min.

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual occupation Pipe Operator

11. Industry or business News-American

FATHER 12. Name Joseph M. Wolf

FATHER 13. Birthplace Baltimore Md.

MOTHER 14. Maiden name Barbara M. Hasselberger

MOTHER 15. Birthplace Baltimore, Md.

16. Informant Mrs. Helen G. Wolf

Address 5512 Selma Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/19/45 (month) (day) (year)

Cemetery or crematory New Cathedral Cem.

Location 4300 Old Frederick Rd

18. Funeral director John L Cowan & Son

Address 901-03 Hollins St.

19. Mch 16 19 45 H. Kieffer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15th 19 45, at 11:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death	
Coronary occlusion	
Due to	
Due to sudden death	
Other conditions Angina	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Dr. H. Kieffer Eaton Hall M. D. or other

Address 1010 Leeds ave Date signed 3-15-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

02695

CERTIFICATE OF DEATH

Reg. Dist. No. 38 45

1. PLACE OF DEATH:
County: Baltimore
City or town: Sweet Air (Baldwin P.O.)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baldwin P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural - Blenheim Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Bessie Ayre Woodward

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband ~~or wife~~: George W. Woodward
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Unknown 1879

8. AGE: Years	Months	Days	If less than one day
65	—	—	...hrs. ...min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Frank Jenkins
13. Birthplace: Virginia

MOTHER
14. Maiden name: Martha Cabbage
15. Birthplace: Virginia

16. Informant: Mrs. Albrey Dodson
Address: Baldwin P.O., Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: March 3, 1945 (month) (day) (year)
Cemetery or crematory: Stradley Funeral Home
Location: Culpeper, Virginia

18. Funeral director: John Burns' Sons
Address: Towson, Maryland

19. Mar 3 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 1945, at 1 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 8 1942 to March 3 1945 and that I last saw h— alive on February 28 1945

Immediate cause of death: Coronary Thrombosis — DURATION: 15 min.
Due to: Hypertension — 3 yrs
Due to: Cardiovascular Disease
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clifford F. Hudson, M.D.
M. D. or other
Address: Fork, Md. Date signed: 3/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

02696

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-21)

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Balto

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 6310 Frederick Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 6310 Frederick Rd
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sophia A. Zimmerman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Joseph C. Zimmerman

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): June 18th 1871

8. AGE: Years	Months	Days	If less than one day
73	8	16	hrs. min.

9. Birthplace: Balto. Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: (Unknown) Hummel
13. Birthplace: Balto. Md.

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: John O. Zimmerman
Address: 6310 Frederick Rd

17. Burial — Date thereof: 3/7/45
(Burial, ~~cremation, or removal. Which~~) (month) (day) (year)

Cemetery or ~~crematory~~: Parkwood

Location: Parkville Md.

18. Funeral director: William Cook Inc
Address: 1217 St. Paul St.

19. 3/6 1945 G. W. Hedrick [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 4th 1945 at 10 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to March 4 1945

and that I last saw her alive on March 3 1945

Immediate cause of death: Carcinomatosis [illegible]
[illegible] Colon - Hypertension
C.V.D. - Arteriosclerosis

Due to

Due to

Other conditions: Pulmonary Oedema
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: Robert C. [illegible] M. D. or other

Address: 451 [illegible] Ave Date signed: 3/5/45

Rec'd by U.S.
3/6/45